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## Legislative Assembly of Ontario

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## Assemblée législative de l'Ontario

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# Official Report of Debates (Hansard)

Tuesday 16 January 2007

# Journal des débats (Hansard)

Mardi 16 janvier 2007

## Standing committee on social policy

Long-Term Care  
Homes Act, 2007

## Comité permanent de la politique sociale

Loi de 2007 sur les foyers de  
soins de longue durée



Chair: Ernie Parsons  
Clerk: Trevor Day

Président : Ernie Parsons  
Greffier : Trevor Day



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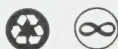
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Tuesday 16 January 2007

Mardi 16 janvier 2007

*The committee met at 0904 in committee room 1.*

## ELECTION OF ACTING CHAIR

**The Clerk of the Committee (Mr. Trevor Day):** Honourable members, it is my duty to call upon you to elect an Acting Chair.

**Mr. Peter Fonseca (Mississauga East):** I'd like to nominate Bob Delaney as the Acting Chair.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** I would second that.

**The Clerk of the Committee:** Are there any further nominations? Seeing none, nominations are closed.

Mr. Delaney, you are the Acting Chair.

**The Acting Chair (Mr. Bob Delaney):** Thank you very much. Good morning, everyone. This is the standing committee on social policy. We are here this morning to begin our consideration of Bill 140, An Act respecting long-term care homes.

## REPORT OF THE SUBCOMMITTEE

**The Acting Chair:** Our first order of business is the report of the subcommittee on committee business.

**Mr. Fonseca:** Thank you, Chair. I'll read in the report of the subcommittee.

Your subcommittee met on Monday, December 11, 2006, to consider a method of proceeding on Bill 140, An Act respecting long-term care homes, and recommends the following:

(1) That the committee request authorization from the House leaders to meet on January 16, 17, 22, 23, 24, 30 and 31, 2007, for the purpose of considering this bill.

(2) That, if authorized, the committee meet in Toronto on January 16 and 17, 2007, and in Kingston, Sudbury and London on January 22, 23 and 24, 2007, for the purpose of holding public hearings.

(3) That the committee clerk, with the authorization of the Chair, post information regarding public hearings for one day in the Ontario English dailies and French weeklies, once authorization has been received by the House.

(4) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on a second day in the local papers of the cities in which the committee intends to travel, once authorization has been received by the House.

(5) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on the OntParl channel and the Legislative Assembly website, once authorization has been received by the House.

(6) That interested parties who wish to be considered to make an oral presentation contact the committee clerk by 12 noon on Friday, January 5, 2007.

(7) That, in the event all witnesses cannot be scheduled, the committee clerk provide the members of the subcommittee with a list of requests to appear by 2 p.m. on Friday, January 5, 2007.

(8) That the members of subcommittee prioritize and return the list of requests to appear by 4 p.m. on Monday, January 8, 2007.

(9) That groups and individuals be offered 15 minutes for their presentation. This time is to include questions from the committee.

(10) That the deadline for written submissions be 12 noon on Friday, January 19, 2007.

(11) That an interim summary of presentations be prepared by the research officer by Thursday, January 25, 2007.

(12) That for administrative purposes, proposed amendments be filed with the committee clerk by 12 noon on Friday, January 26, 2007.

(13) That the committee meet for the purpose of clause-by-clause consideration on January 30 and 31, 2007.

(14) That the clerk of the committee, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

**The Acting Chair:** Thank you very much. Is there any discussion on the subcommittee report? Ms. Martel.

**Ms. Shelley Martel (Nickel Belt):** Thank you, Mr. Chair. Very briefly, I'm going to be voting against the subcommittee report. The reason is that during the meetings of the subcommittee I encouraged the other members to consider more days for public hearings. I felt there was going to be significant interest in this bill and that we would receive more requests than we could deal with as a result, and I think that has been borne out. In Toronto, we received 96 requests and are able to accommodate only 48 organizations and individuals. In London, 31 requests, 24 folks being accommodated; In



Kingston, 42 requests, and 24 individuals and organizations are accommodated. I think we could have used the extra days that I had suggested and we probably could have heard everyone who wanted to be heard. So on that basis, I'm going to vote against this subcommittee report.

**The Acting Chair:** Thank you. Are there any further comments on the subcommittee report? Adoption of the subcommittee report?

**Ms. Martel:** Recorded vote, please, Chair.

#### Ayes

Fonseca, Mauro, Sandals, Smith.

#### Nays

Martel.

**The Acting Chair:** I declare the report of the subcommittee to be carried.

#### LONG-TERM CARE HOMES ACT, 2007

#### LOI DE 2007 SUR LES FOYERS DE SOINS DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

#### PSYCHIATRIC PATIENT ADVOCATE OFFICE

**The Acting Chair:** Our first deputation this morning is Mr. Bernard Maheu. Is Mr. Maheu here? Oh, I beg your pardon. My error. The first deputation would be the Psychiatric Patient Advocate Office, David Simpson and Lisa Romano. Unfamiliar formatting here.

Good morning and welcome. You'll have 15 minutes to do your deputation. If you leave any time remaining, it will be divided among the parties for questions. Please begin by introducing yourself for Hansard and then proceed.

0910

**Ms. Lisa Romano:** Good morning. My name is Lisa Romano. I'm legal counsel to the Psychiatric Patient Advocate Office. With me is David Simpson, acting director of the PPAO. We would like to thank the committee for this opportunity to share our recommendations with you in the hopes that they will be adopted to strengthen Bill 140.

Due to time constraints, we will not discuss all the topics contained in our submission, but we trust that you will consider the submission in its entirety. Today we will be primarily focusing on the issues of rights advice and restraint.

For the past 20 years, the PPAO has been providing rights advice in the mental health sector. Presently we

deliver the majority of rights advice in the province. In 2005, our rights advisers met with individuals on over 25,000 occasions, in 48 different languages.

Rights advice is a process by which patients in psychiatric facilities and persons being considered for community treatment orders and their substitute decision-makers, if any, are informed of their rights when their legal status has changed. For example, if a person is found to be treatment-incapable, then he or she is unable to make decisions about treatment and another person, the substitute decision-maker, is able to consent to treatment decisions affecting the person's bodily integrity.

The role of the rights adviser is to explain the significance of the legal situation to the affected individual and to discuss some of their options. The rights adviser will also assist the individual, if they so choose, to apply for a hearing before an administrative tribunal called the Consent and Capacity Board to challenge this change in legal status. They will also assist the person to obtain a lawyer and to apply for financial assistance. Thus, rights advice is an integral check and balance that serves to protect the rights of the individual in the system.

Now I'm going to briefly discuss admission or transfer to a secure unit in a long-term-care home, which can be found on page 7 of our submission.

Bill 140 requires the provision of rights advice to residents who are found incapable of consenting to their admission or transfer to a secure unit where substitute consent has been provided. Residents are prevented from leaving secure units. Individuals are able to challenge their admission or transfer to the board, to determine whether the substitute decision-maker has complied with the principles of giving or refusing consent.

As the admission or transfer to a secure unit is effectively an involuntary admission within a long-term-care home, the liberty interests of the individual must be protected. Therefore, the PPAO believes that every person being admitted or transferred to a secure unit should receive rights advice in order to understand the implications of being detained on a secure unit.

The PPAO believes that Bill 140 lacks a framework to protect residents who remain on a secure unit for an indeterminate amount of time. Timelines should be enacted for both the regular provision of rights advice and the review of decisions to keep residents on secure units in order to safeguard their liberty interests and maintain accountability. With this in mind, the PPAO recommends that residents detained on a secure unit be required to obtain mandatory rights advice every six months. Moreover, the Consent and Capacity Board should hold a deemed review once per year in cases of continued admission on a secure unit.

The proposed legislation also needs to provide for the written confirmation of rights advice and the creation of a regulated form similar to the current form 50 that exists for mandatory rights advice situations under the Mental Health Act. This form should provide clear information as to whether rights advice has been provided and whether the person has applied to the board.



I am going to speak now for a few minutes about expanding rights advice situations. This can be found on page 6 of our submission.

While the PPAO commends Bill 140 for requiring the provision of rights advice for transfers and admissions to secure units in long-term-care homes, we believe that enhanced rights protections should be extended in four additional scenarios. I will briefly discuss each of these situations.

First, where a health care provider finds a person incapable of consenting to admission to a long-term-care home, the person is not entitled to rights advice. The health care provider is only obliged to provide the person with rights information. We submit that rights advisers are better able to assist individuals in this regard due to their experience and impartiality. For example, some individuals may feel awkward or uncomfortable asking the person who found them incapable for additional information in order to challenge that finding. Therefore, the PPAO recommends that rights advice be provided to all incapable individuals facing admission to a long-term-care home.

The second situation occurs where an individual is a patient in a psychiatric facility and has been found incapable of managing his or her property. Prior to discharge from the psychiatric facility, a notice of continuance of inability to manage property, which is referred to as a form 24 under the Mental Health Act, must be completed by a physician. A rights adviser is then to meet promptly with the person to explain this finding to them and to explain to them their rights. If patients have not submitted an application to the board prior to discharge, they are precluded from having this decision reviewed once they're in the community. Unfortunately, individuals are often discharged after receiving the form 24 but before receiving rights advice, and some patients are discharged shortly after receiving rights advice but before they have the opportunity to apply to the board. These situations are especially true of those being admitted to long-term-care homes due to the risk of losing a bed if the admission does not take place quickly. Once individuals are at the hospital, if they wish to challenge the finding before the board, they must undergo another capacity assessment at their own expense. This kind of assessment usually costs hundreds of dollars.

To remedy this situation, the PPAO recommends that residents receive rights advice when a form 24 is issued but where rights advice did not take place prior to the admission to a long-term-care home and that the existing legislation be amended to allow the board to accept these applications. Also, rights advice should be mandatory within a long-term-care home where a capacity assessor finds a resident to be financially incapable.

Finally, under existing law, if patients of a psychiatric facility are found to be incapable of making a decision about their treatment for a mental disorder, rights advice is mandatory. However, residents of long-term-care homes are not afforded the same right, despite the fact that residents are also members of a vulnerable popu-

lation. Due to this loss of personal autonomy, the PPAO recommends that the legislation stipulate that rights advice must be provided to residents of long-term-care homes.

Mr. Simpson will now continue with the remainder of our submission.

**Mr. David Simpson:** Good morning. I would like to spend the next few minutes addressing the issue of restraint and the implications for individuals in the long-term-care sector, as well as some of the myths and misconceptions about the use of restraint. In our submission you'll find our comments and recommendations beginning on page 8.

In 2001, our office conducted a study on the use of seclusion and restraint in provincial psychiatric hospitals, and we made 23 best-practice recommendations on the basis of our findings. Some of the results were troubling, particularly the frequency of the use of seclusion and restraint and what was perceived by health care providers as an environment that was permissive and tolerant of the use of restraint. Consequently, we have advocated for the mental health sector to move towards becoming a hands-free, restraint-free environment. Our report has been used by many hospitals in the development of their policies, and we believe that many of the best-practice recommendations are applicable to the long-term-care sector.

Bill 140 falls short of protecting residents' rights by including restraint in the plan of care. Restraint seriously limits individual autonomy and is associated with significant physical and psychological risks. The benefits of restraint may be difficult to ascertain, while risks of morbidity and mortality are well documented.

I would now like to address some of the myths and misconceptions about the use of restraint. There are some who believe that a resident in restraints is safer and requires less supervision. On the contrary: Such residents are at an increased risk due to health complications if the restraint is inadequately monitored and supervised. Restrained residents are unable to protect themselves from aggressive co-patients. Also, if the restraint is misapplied, it can cause life-threatening injuries or even deaths. The results can be tragic. Although some staff members view restraints as safety and protective devices, they are often misused, overused and inappropriately used as a way to manage difficult clients: those who wander or who would otherwise require higher levels of supervision.

As a rights protection organization, we are concerned that this legislation fails to even define "restraint." There are many different types of restraint, including physical, chemical and environmental. Without a clear and concise definition included in the law, its usage is open to uncertainty and, potentially, abuse.

#### 0920

The legislation also permits care providers to include restraint in the resident's plan of care. By definition, "care" includes all dimensions of treatment and intervention. Bill 140 says that restraint can be used when a resident is incapable, but it does not articulate the nature



of the incapacity: Is it referring to incapacity to consent to treatment decisions, incapacity to consent to the plan of care or incapacity to consent to the restraint itself? Thus, it is unclear in Bill 140 whether restraint is considered to be a treatment as defined in the Health Care Consent Act, because there is no definition of "treatment." If it is treatment, then there must be a determination by a health care provider of the person's capacity to give consent to restraint.

For persons found to be incapable, consent must then be given by a substitute decision-maker. If restraint is not considered treatment, but still requires consent for inclusion in the plan of care, then how and under what authority would capacity be determined? Also, under what authority would a substitute decision-maker consent to the use of restraint outside of the context of treatment? What would be the resident's right of review, if any, before the Consent and Capacity Board?

It is our position that restraint is not treatment and we would recommend that it be clearly defined from treatment. Therefore, the PPAO recommends:

- the inclusion of a clear and comprehensive definition of "restraint" for physical, chemical and environmental methods;
- the omission of restraint from the plan of care;
- that "restraint" be clearly distinguished from "treatment";
- that it be considered a means of managing emergent situation where the risk of serious bodily harm to the resident or others is imminent;
- the inclusion of crisis intervention plans in the plan of care with consent and the involvement of both the resident and their substitute decision-maker, if any; and
- the establishment of a written documentation standard within the proposed statute or its regulations, requiring a detailed account of regular, relevant occurrences, interventions and outcomes.

Documentation and reporting standards are essential if residents of long-term-care homes are to be protected from abuse. Staff in long-term-care homes should be trained and certified in crisis prevention and crisis intervention techniques.

Although we don't have time today to address all of our concerns, we would like to draw your attention to other recommendations, such as on page 11, the need to appoint an independent seniors' advocate to protect the legal and civil rights of seniors residing in long-term-care facilities; on page 14, the importance of appointing a seniors' ombudsman to report on the state of long-term care in Ontario and to receive complaints from all stakeholders, including the independent seniors' advocate; the benefit of strengthening resident and family councils by providing adequate funding and autonomy with funding and reporting relationships; and the provision of legal sanctions to hold every person who contravenes any provision of this legislation accountable for their actions.

Bill 140 will affect the quality of care and life of all residents in long-term-care homes for this and future generations to come. It's for this reason that we must get it right. Our challenge is to work together to strengthen

rights protections for Ontario seniors and address issues related to quality of care and life. Adopting our recommendations is the first step in making the system both responsible and accountable to the people it serves.

**The Vice-Chair (Mr. Khalil Ramal):** Thank you for your presentation. We don't have any time left. Thank you very much.

#### BUD MAHEU

**The Vice-Chair:** The second presentation will be by Bernard Maheu. Welcome, sir. You can start whenever you are ready.

**Mr. Bud Maheu:** Thank you, Mr. Chairman. Ladies and gentlemen, my name is Bud Maheu. I am the president of the residents' council at the Gibson Long Term Care Centre, a 202-bed class C home in North York. At retirement, I was the director of international trade programs at the Toronto Board of Trade, I was a member of various committees and I participated in submissions to the three levels of government on different issues. I also lectured to students at colleges and universities on international trade and I participated in forming the postgraduate international program at the University of Waterloo.

After my retirement, I completed projects for the Canadian federal government and for my former employer, the Toronto Board of Trade.

Shortly after my wife's passing about a year and a half ago, I had an allergic reaction to Lipitor. The resulting muscle weakness is what brought me to Gibson's.

Now, about the bill: As president of the residents' council, I applaud Bill 140 for putting pressure on all LTC centres to assure and standardize as much as possible protection and safety in all areas, such as physical, mental, diet and nutrition, religious beliefs, duties of nurses etc. for the residents. In these regards I can honestly say that Gibson's goes to great lengths to ensure that these issues are addressed appropriately.

However, Bill 140 provides two primary areas of concern. My first area of concern is licensing. I strongly believe that a licence should not be issued or renewed when there has been non-compliance of rules, false statements made and/or inability to establish the need for such a home in the area. However, I am opposed to section 101, where it states, "(5) The director is not required to provide reasons for deciding whether or not to issue a new licence." The granting or not granting of licences should be an open and transparent issue.

I am also deeply concerned with the proposed changes to the licensing period for all homes. I would base renewal on a home's structure. All homes that meet the requirements of the current act, regulations and service agreements have their licences renewed annually. However, under Bill 140, the proposed term of the licence will be determined by the structural classification of the home—A to D inclusive—with A homes being licensed for 25 years and C homes being licensed for only 10 years. As president of the residents' council, I certainly



cannot condone such action. Instead, I believe that the current one-year licensing term should be maintained for all homes.

My second area of concern is financing. I understand that under Bill 140, the government can try and force an operator to invest millions of dollars in upgrading just to get their licence renewed. I don't know who would finance such a venture when they wouldn't know how long the home would even have their licence for. From a fiscal point of view, a defined long-term period is necessary to plan the appropriate finances.

I have concerns about the homes that have three- and four-bed wards: class B and C homes. These homes were approved a few years ago but will no longer be acceptable. I understand that in all new homes, the wards consist of two beds with a shared bathroom. Gibson's has four-bed wards and is classified as a C home. I believe that three- and four-bed wards must be converted to two-bed wards within a reasonable length of time. But government funding will be required to assist the operators to perform such rebuilding. I understand that government funding was provided for homes built since 1998 and class D homes that have recently been rebuilt.

On behalf of the residents at Gibson's I ask, why is this program not available to assist us in our home? I was told that the operator of Gibson's has already invested some \$3.1 million to upgrade the building and is budgeting another \$500,000 in fiscal year 2006-07. You can see the difference this investment has made and is making with the interior appearance. Yet, despite their best efforts, they could get rid of the four-bed wards or make the bathrooms bigger so that residents like my friend Eleanor can go to the bathroom in their wheelchairs. And so, Gibson's remains a class C home. In tying a home's licence to its classification, it would be very difficult for a class C building such as Gibson's to approach a financial institution about a loan with a 25-year amortization to cover their share of the cost of reconstruction and all other expenses to upgrade to a class A home when their licence expires in only 10 years. So, if these financial issues cannot be resolved, what happens after 10 years? Do we still live with three- and four-bed wards, or does the government close these homes, effectively putting residents out on the street and laying off staff, some with many years of service?

In summary, my primary areas of concern are licensing and financing. Licences should be renewed annually, the renewal process should be open and transparent, and the licensing should not be tied to the structural classification of the home. By eliminating the connection between a home's licence and its structural classification, and government committing to the same capital program that exists now for other homes, the operators of class B, C and D homes have the opportunity to obtain suitable financing to upgrade their facilities to a class A residence.

Thank you, ladies and gentlemen, for your time.

0930

**The Vice-Chair:** Thank you very much, sir. We have a lot of time left, about seven minutes. We will divide it

equally between the three parties. We'll start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Mr. Maheu. I really appreciate your presentation. I think it's so meaningful when you, as a resident and someone who's representing the other people in the home, come forward and express your concerns.

You're saying you would prefer the continuation of the one-year renewal as opposed to this renewal that's based on the age of the home, and I would certainly agree with you. You feel confident that the current program in place, where the renewal is based on one year at a time and not on the structure, would give security to the residents, because the one thing we keep hearing is that this new proposal based on the age of the home is creating a lot of uncertainty for people. The fact that the government doesn't have to give any reason for pulling your licence, of course, provides further concern. Can you speak to that?

**Mr. Maheu:** I'll certainly try. At the moment, it's being renewed on an annual basis.

**Mrs. Witmer:** That's right.

**Mr. Maheu:** As long as you follow your Ps and Qs, there's no reason why a financial institution would not loan you money as they have before, certainly over a long-term amortization plan. However, with Bill 140, as I see it, anyway, there's a 10-year structure here. At the end of seven years they may, if they wish, come along and say, "Your licence will not be allowed to be extended after three years," which means, what do you do if you already have a 25-year-old plan, if someone is silly enough to loan it to you, that is?

**The Vice-Chair:** Thank you very much. Ms. Martel.

**Ms. Martel:** Thank you very much for being here this morning, for taking the time to make the presentation. I was interested very specifically in your concerns with respect to section 101, where the director does not have to provide reasons whether or not to issue a new licence. I agree with you that it should be a public matter, but I'm wondering if you can tell the committee why you have a concern that would lead you to that conclusion in the first place.

**Mr. Maheu:** Gosh, I gave that a lot of thought. I find it very difficult to answer, because I certainly believe that no government in power would ever do this and expect to get re-elected in the next term. Nevertheless, the wording is still in Bill 140, so theoretically it could happen.

**Ms. Martel:** So your concern is that if there is a reason that a home is not getting the licence, that should be very public. Perhaps it will act as a deterrent to other homes to get their act in order if they are out of compliance. Is that how you see it?

**Mr. Maheu:** That is how I see it. I can imagine what the local press would say too. If a long-term-care home did everything it should have been doing, followed all the inspections, and had no black marks against it, and then the residents were suddenly put out on the street, here in Canada where it can get cold, I'm sure the press would make big headlines on that. However, the possibility is there.



**The Vice-Chair:** Thank you, Ms. Martel. The parliamentary assistant.

**Ms. Monique M. Smith (Nipissing):** Mr. Maheu, I'd like to thank you for being involved in your resident council. It's so important that we have residents' councils in all of our homes and that we hear the voices of residents as we move forward on this legislation. So I'd like to thank you for coming today.

Your concern—I just want to pick up on what Ms. Martel was talking about: the notice and the discussion with the community around possible changes to a home. I note that in subsection 101(4) there is a duty on the director to consult with the public; it's outlined in section 104. Section 104 actually sets out when the director has to consult with the public. It's before issuing a licence for a new home, undertaking to issue a licence under section 98, deciding whether or not to issue a new licence, transferring a licence or beds, or amending. So there are provisions in the act for public consultation around the decisions of the director. Does that in any way calm your concerns around transparency? There is the ability to have public consultation—actually, a requirement, not just the ability.

**Mr. Maheu:** I suppose only to a degree. When I read that article on subsection (4), I felt very good about it. Then I read (5), and I thought, "Oh, my goodness, that is contradictory to what (4) says." That is why I emphasized subsection (5).

**Ms. Smith:** Right. Okay.

**The Vice-Chair:** Thank you very much.

#### ONTARIO LONG TERM CARE PHYSICIANS

**The Vice-Chair:** The next presentation will be by Ontario Long Term Care Physicians. I have two names here on the list. If you would state your name before you start, if you don't mind.

**Dr. Norman Flett:** Good morning, Mr. Chairman and committee members. I'm Dr. Norman Flett, medical director at St. Joseph's Villa. With me are Dr. James Edney, medical director at Castlview Wychwood Towers, and Dr. Peter Bolland, who is medical director at Sheridan Villa.

I'm very proud to be here this morning to represent the 580-some medical directors across the province of Ontario and the 2,500-plus attending physicians who look after our residents in long-term-care homes and who are expert in low tech and high touch—low-tech, high-touch medicine. Together the three of us here represent 93 years of practice in the province of Ontario as medical directors and attending physicians. Dr. Edney is going to make the presentation to the committee today. Thank you.

**Dr. James Edney:** Good morning. There has been a profound change in both the type of resident admitted to long-term care and the care culture over the last 30 years. In the 1970s, the average age of a resident admitted was in the late 60s. The resident had reasonable health, with one or two diagnoses. The average number of medi-

cations was less than three, and some of the residents even drove their own car and were able to vacation out of the province. The three acts that we still work under were appropriate to the population of the time. Also, the three acts were passed when the management culture was one of structure, policies, procedures; the time of QA, quality audit. It was long before the current patient—resident—safety culture.

Our assessment of the present act is that the contents of the old acts have been moved into Bill 140 without consideration of the management changes or the type of resident admitted to long-term care. We find this paradoxical, that a government that prides itself on not micro-managing systems and on being at the cutting edge of health care should limit its vision to a bill that is micromanaging par excellence and, in our opinion, is not at the cutting edge, as it does not recognize continuous quality improvement or patient safety.

We believe this act will result in the care of the institutionalized elderly being mired in a morass of inspection, reporting, blame and punishment. This will inhibit innovation and the fostering of a culture of care and safety.

We're very concerned that recruitment and retention of physicians as well as nurses, especially nurse managers, and other staff and administrators will be adversely affected by this bill. We predict that if this act passes in the present or even a mildly altered state, the recruitment of physicians for any home will be almost impossible.

The average age of physicians providing care to residents in long-term-care homes is close to 60 years. There are two implications we draw from this: (1) these physicians are very close to retirement and may indeed take that option, and (2) there are very few younger physicians willing to take on the demanding and poorly remunerated care of the elderly. The recruiting and retaining of physicians and senior long-term-care home staff are critical for the management of our institutionalized elderly.

Bill 140 emphasizes individualized care, and care to the "greatest extent" possible. Individualized care comes with a great economic cost and falls way short at the present time. Care must not endanger other residents or staff. It must allow for the institution to function effectively and must foster a living and working environment that promotes a culture of care, safety and community for residents and staff.

#### 0940

We draw your attention to seven areas of this act that cause us major concern.

(1) The fundamental principle: We believe the fundamental principle is unrealistic. It does not address the present, let alone the future, environment of the long-term-care home. It is inaccurate because of what it leaves out. The residents admitted to a long-term-care home have deterioration in their health in the broadest sense. They are frail. They have five or more diagnoses, an average of nine medications and require assistance in a number, if not all, activities of daily living. The act fails to address the fact that the reason for admission is due to

illness/ill health which cannot be reversed. Our recommendation is to include these realities so that the future residents and their families are not deceived or lulled into thinking that admission to a long-term-care home is equivalent to or better than their own home.

(2) Residents' rights: Residents' rights are presently in regulation. We believe this is appropriate and that the residents' rights should stay in regulation. Here is an example and a reason why. The example: If you look at resident right number 14 and the first part of that, it says, "the right to communicate in confidence." We interpret this as meaning that a physician or nurse discussing symptoms or signs, medications and care with a resident must do it without anyone else hearing the exchange. First of all, what about the residents in the two- and four-bed rooms that are not up to present design standards?

Secondly, this right goes against the physiological consequences of aging that everyone in this room will experience as they get older. By the mid-80s, all persons will have a significant degree of hearing loss. This hearing loss is mainly high-tone, i.e., the female voice, but also affects lower tones. That's why you hear people complaining about female staff shouting. So if someone else—other residents, family, friends of other residents, volunteers—hears the discussion, an offence has been committed and must be reported.

Now the reason: What happens in a number of years—10, 15, 20—when this government will long have been consigned to the history books and a new resident right becomes important to the elderly? The future government will have to open the act in order to ensure that it also follows the course of inspection, monitoring, enforcement and penalties. When you consider all of the rights—all 26 of them—we believe it will be impossible not to commit frequent, daily, even hourly, offences, which of course will need to be punished because they are against the law.

(3) The plan of care, section 6: Subsection (10) outlines the documentation requirements. Physicians have documentation requirements mandated by the College of Physicians and Surgeons. This act may be in conflict with these requirements. If there is no conflict, then how does the physician fulfill the requirements of this section? How detailed must the plan of care be to meet the standard implied in section 22? For instance, documenting the plan of care for a resident with diabetes or dementia could take a number of pages if one outlined all the guidelines and possibilities. The result will be nonsense documentation, more failure and therefore more offences and punishment. Current requirements for documentation already remove staff from bedside care. This is not in the best interests of the residents. This legislation provides an unnecessary layer of inspector scrutiny for attending physicians in long-term care, which will drive physicians from the care of the elderly.

(4) Sections 22 and 23: These two sections completely ignore the continuous quality improvement culture the medical system has embraced. We expect physicians will refuse to do audits to see if care could be improved

because of the risk of exposing care that might be judged as improper or incompetent by an inspector. These sections are counterintuitive to the patient/resident safety culture that the health care system is also embracing. The present culture of safety is to encourage staff to report all misses and all near misses so that the system can be improved for the safety of residents and patients, so near misses and anticipated misses will not be reported for fear of penalty. For example, what of the phone call to the physician who is not in the home who is busy and doesn't respond immediately? Is this included in the risk of harm and therefore open to penalty?

(5) Section 74, training: The whole act is confusing in respect of whether physicians and medical directors are staff or not. We read the act as that both are staff, so all physicians will need the training prescribed in this section. This is onerous in the extreme, particularly as the physicians are trained already in a number of areas: restraints, caring for persons with dementia etc.

(6) Compliance and enforcement: This is the most ill-conceived part of the act, in our opinion. It pits the inspectors against the staff, staff against staff, residents against staff, families against staff, all setting up inevitable failure. It provides no support for the residents who have chosen the home and no support for the staff who are often working in very compromising circumstances. It does not distinguish between the spilled banana purée—a risk of a fall—and murder from an aggressive resident for whom we may have little information. We are not to use medication, restraint or locked units for fear of breaking this law.

(7) Penalties: When one considers the likelihood that offences will be committed daily, if not hourly, the penalties are clearly excessive.

Overall, we feel that this act requires diligent revision so that the principles of continuous quality improvement and patient safety are more clearly enunciated. We need to ensure that homes can be flexible in the provision of care and innovative in meeting the needs of present and future residents. In its current form, we see it as very bad for residents, neither helping them obtain good care nor allowing staff to meet their needs. We predict that it will be very difficult to persuade physicians to be medical directors or attending physicians to work in the homes. We are also concerned that our remarks on retention and recruitment will almost certainly apply to nurses and other staff.

In summary, we advise the government to:

- reword the fundamental principle to include the realities of residents of 2007 and the future;

- keep the bill of rights in regulation;

- put the documentation requirements into the regulations;

- rewrite sections 22 and 23 and the sections on inspection and enforcement using the principles of CQI and patient/resident safety;

- return the training requirements to regulation; and

- make the penalties appropriate to the issue.

Thank you for your attention. We'd be pleased to take questions.



**The Vice-Chair:** Thank you very much. We have a few minutes for questions. We'll start with Ms. Martel.

**Ms. Martel:** Thank you very much for being here today and for your presentation on behalf of yourself and your colleagues.

Number four in the summary says, "Rewrite sections 22 and 23," and it also references the "principles of CQI and resident/patient safety." When you talk about the principles of CQI and resident/patient safety, what are those principles? Are those standard principles that are used across homes? I'm sorry to display my ignorance, but I don't understand what the reference is to.

**Mr. Flett:** Yes, they are. These are situations that are highly individual depending on the capability or incapability of the individual resident. When we look at their strengths and weaknesses, continuous quality improvement is a way that we review those on an ongoing basis to see how we in fact can best manage that individual in the environment in which they are in.

**Ms. Martel:** So if you wanted to put that into the—

**The Vice-Chair:** Thank you, Ms. Martel. The parliamentary assistant?

**Ms. Smith:** Just to follow up on sections 22 and 23: Sections 22 and 23 are the duty to report neglect and abuse and improper or incompetent treatment. Are you suggesting that we should be removing that duty to report? Is it not in the best interest of our residents that we ensure that any abuse and neglect are reported?

**Mr. Flett:** It is in their best interest. The way that it is worded, and the penalty for that, is such that there will be a lot of justification and staying in terms of where they were at, that no neglect in fact was permitted. When we have had an error—particularly an error in dosage of medication, which could be an error in terms of the resident directly—we want those to be reported so we can look at the system.

**The Vice-Chair:** Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. Were you consulted at all in the drafting of this legislation?

*Interjection.*

**Mrs. Witmer:** So this is the first opportunity?

**Mr. Flett:** We had an opportunity to present at a committee that was looking at the white paper, and we noted that the word "physician" is in the white draft on two occasions. On those occasions, it was to be associated with the nurse practitioner taking activity away from physicians.

**The Vice-Chair:** Thank you very much.

**Mrs. Witmer:** Oh, okay.

**The Vice-Chair:** Sorry. We don't have enough time. Thank you very much for your presentation.

#### ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

**The Vice-Chair:** The next presentation will be by the Ontario Association of Community Care Access Centres.

You can start when you're ready. If you don't mind, state your and your associate's name before you start.

**Ms. Georgina White:** Good morning. I'm Georgina White, the director of policy and research with the Ontario Association of Community Care Access Centres. I'm here with Sheila Jaggard, who is our vice-president of member services and chief operating officer. It's a pleasure to have the opportunity to speak to you today.

**0950**

The Ontario Association of Community Care Access Centres is a voluntary organization that represents Ontario's CCACs. As the provincial voice for CCACs, the mission of the OACCAC is to represent the interests of our members, to act as a vehicle for the development of common policy and shared services, to provide leadership in shaping health care policy and to promote best practices on behalf of the people served by community care access centres.

As you may know, CCACs have been planning a major reorganization over the last year and, as of January 1 of this year, we have consolidated our 42 organizations into 14 new organizations that are aligned with the LHIN boundaries.

Each year, CCACs provide coordinated access to health and support services to approximately half a million clients in Ontario. Through our case managers and care coordinators, our information and referral processes, CCACs play a major role in promoting independent living, helping people to navigate through the health care system and providing a bridge to other health care services. Within this mandate, CCACs have the legislated responsibility to act as the placement coordinator for people seeking access to long-term-care homes on both a long-term and short-term basis.

We're responsible for assessing individuals' needs and eligibility for placement and helping individuals and families to find homes with programs and services that meet their physical, behavioural, cultural and spiritual requirements and their preferences. CCACs also determine priority for placement and manage the wait-lists for placement, and we work with long-term-care homes to coordinate the admissions process. Last year, CCACs managed over 50,000 new referrals for placement and coordinated approximately 44,000 admissions to long-term-care homes.

Before I begin my comments on the bill, I want to congratulate the government for bringing this long-anticipated bill forward and for the principles and values reflected in the legislation, specifically the recognition that a long-term-care home is a home where residents have the right to live "with dignity and in security, safety and comfort." Long-term-care homes are not like acute care hospitals where people may spend a few days or weeks. They are homes where thousands of Ontarians go to live each year, often for the final months and years of their lives.

We were grateful to have the opportunity to participate in the consultation process undertaken by Parliamentary Assistant Monique Smith. I also want to express our

special appreciation to the team in the Ministry of Health and Long-Term Care that worked on this bill for their willingness to meet with stakeholders, to answer questions and receive feedback.

With respect to the preamble and principles, one area of concern for us, I think as you've heard before us, is the absence of a commitment to supporting continuous quality improvement. Both the Commitment to the Future of Medicare Act and the Local Health System Integration Act include continuous quality improvement as a fundamental principle. Bill 140 focuses instead on compliance with and enforcement of specific standards of care and services. We would suggest that compliance with standards that may or may not be evidence-based is not the same as a fundamental commitment to quality that acknowledges and rewards innovation and the pursuit of excellence.

Part III of the act deals with the admission of residents and is most pertinent to the placement responsibilities of CCACs. Section 41 deals with the assessment requirements for eligibility and determining an appropriate placement, and section 42 deals with authorization for admission. Under subsection 42(7) the placement coordinator, the CCAC, must provide copies of an applicant's assessment to the home selected by the applicant to determine if the home is able to meet the applicant's needs. In practice, in the absence of an electronic system for transmitting an assessment and assessment results, this entails faxing a multi-page, very-small-print document to the home that is difficult to read and may not provide information in a useful form to the home.

In consultation with long-term-care homes, a summary document or personal health profile has been developed that summarizes the relevant findings of the assessment. This profile, as opposed to the raw assessment data, is sent to the home in the majority of cases. It's not clear in the current wording of this section if it would permit the continued use of this personal health profile. To clarify, we would suggest a minor amendment to that subsection that would require the assessment results or personal health profile to be provided rather than the raw assessment data to ensure that homes have access to information that is useful and specifically designed to assist in their decision-making. The full assessment could be made available at the home's request rather than as a routine requirement.

Section 43 addresses admissions to secure units and includes new requirements for individuals to receive written notice and have access to a rights adviser in situations where the consent is given by a substitute decision-maker. These provisions mirror section 30, which deals with internal transfers to secure units in the home. The designation and characteristics of rights advisers are yet to be described in regulation.

While we support the underlying principles of respecting individual autonomy, minimizing restraints and maximizing the protection of vulnerable people, we are concerned that this is one example of several areas where the act sets out operational and procedural requirements

that may be difficult to implement effectively. This could have unforeseen consequences that negatively impact the care and safety of individuals. It's not unusual for admissions to secure units to be carried in the context of a crisis for the family or the individual who requires a very rapid response. If rights advice is not available within hours, these requirements could leave vulnerable applicants or their family caregivers at risk or potentially result in inappropriate admissions to acute care hospitals. In the absence of the operational details about how a rights advice program is to be implemented and assurance that a rapid response capability will be there, we suggest that it's inappropriate at this point to include this as a requirement in the legislation. We recommend that consideration be given to moving these requirements to regulations, where they're enforceable but can more easily be adjusted if they prove unworkable or have unforeseen negative consequences for individuals and the health care system.

Section 76 sets out the requirements for information packages to be provided to residents, again with a long list of specific contents. We suggest that this is another area where the details may be better left to regulation to ensure that the information provided is responsive to residents' needs on a long-term basis. Further, much of the information in this list is standard information across the system, such as the Residents' Bill of Rights and charging policies. We recommend that a standard information package be developed by the province that could be augmented with information specific to the home to minimize the administrative burden on homes.

We recognize the government's need to be responsive to the issues and concerns raised by individuals and families through the consultation and to ensure an open and transparent process. While the legislative process provides this transparency, this is counterbalanced by the difficulty in amending legislation. The regulatory process can be less open, but it provides a greater capacity to make changes and adjustments over time.

Beyond the legislation, the anticipated regulations under the Long-Term Care Homes Act will have significant impact on CCACs, and we would encourage the government to continue to consult with our sector and other stakeholders as regulations are developed.

I have just a couple of additional comments.

Section 85 requires homes to develop emergency plans that address procedures for evacuating and relocating residents in the event of an emergency. As a matter of practice, long-term-care homes would consult with CCACs and other key stakeholders, including local health integration networks, in the development of such plans. However, we would suggest adding a requirement for consultation and for sharing a copy of the plan with CCACs to ensure that CCACs are prepared to assist as necessary.

Finally, on a somewhat lighter note, I want to wholeheartedly support the name change of the Long-Term Care Act to the Home Care and Community Services Act under section 208. This new name better reflects the



scope of this act and recognizes that not all home care and community services are provided on a long-term basis.

On behalf of CCACs and our association, we are grateful for the opportunity to share our views on this important piece of health care legislation. We'd be happy to respond to your questions.

**The Vice-Chair:** Thank you very much for your presentation. We'll start with the parliamentary assistant.

**Ms. Smith:** Your recommendation under section 76 about the information package: I know that as a CCAC you deal with a number of homes in your area. I think you would agree with me that the information that homes provide to residents is somewhat inconsistent, and we've certainly heard from residents' family members that they want more information. That would be the reason that we've put that requirement in the legislation. I just want to make sure you would agree with me that the information being provided to the residents and their families is necessary, but what you're saying is that you'd like to see the details more in the regulations than in the legislation. Is that basically your—

**Ms. White:** That's right; again, so that it could be evaluated over time. It may be that some pieces of information are more useful to people than others. Obviously, you have the ability to continue to add to that list as necessary.

**Ms. Smith:** Right, and we do. In the reg-making authority we do provide for additional information.

**Ms. White:** Yes. But I think ideally you'd want to have some flexibility with that list so that we're not overloading people with information that ultimately may not be useful to them.

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**Ms. Smith:** Right. Okay, thank you.

**The Vice-Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation. We're starting to hear a bit of a little theme here about the concern of the absence of a commitment to supporting continuous quality improvement. Maybe you could expand on that. We're hearing a lot about this bill being quite prescriptive and focusing on compliance and enforcement. What type of recommendations would you recommend for the government as they amend this bill, specifically?

**Ms. White:** I think our key recommendation would be that continuous quality improvement ought to be a concept that's reflected in the principles of this act, as it is in other significant pieces of health care legislation. What we've heard from the homes that we've spoken to is a concern that the heavy emphasis on compliance with standards can distract from an environment that focuses on quality improvement and innovation, that kind of approach to the provision of care.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** I want to just focus on the profile that you refer to. Is that standard across long-term-care homes now, or has that just been developed in certain regions of the province?

**Ms. White:** The RAI home care tool is used right across the system now as our standard assessment tool for placement, and the personal health profile is basically a form that's developed based on the assessment results from that RAI.

**Ms. Martel:** In your view, though, is it full enough to give the home a significant understanding of the individual who wants to be admitted?

**Ms. White:** It was developed in consultation with homes, based on their specific requirements for information, and the practice at this point is to provide the actual RAI results if they are requested.

**The Vice-Chair:** Thank you very much for your presentation.

## SERVICE EMPLOYEES

### INTERNATIONAL UNION, LOCAL 1.0n

**The Vice-Chair:** The next presentation will be by the Service Employees International Union, Local 1.0n. I believe we have with us Sharleen Stewart, the president, and, for Hansard—

**Mr. John Van Beek:** John Van Beek.

**The Vice-Chair:** Thank you very much. You may start whenever you are ready.

**Ms. Sharleen Stewart:** First, I'd like to thank the members of the committee for allowing the Service Employees International Union to address our concerns this morning on Bill 140. As indicated, I am Sharleen Stewart. I am president of SEIU Local 1.0n.

The Service Employees International Union has been fighting for better nursing home care standards for years. SEIU Local 1.0n. represents approximately 12,000 nursing home workers—registered practical nurses, health care aides, personal support workers, dietary and house-keeping aides, and maintenance staff—at more than 140 nursing home facilities across Ontario.

I will be jumping around this morning, so please bear with me and hopefully just sit back and listen.

Seniors in Ontario nursing homes are still not receiving the care they deserve, and Bill 140 will entrench the fact that Ontario will continue to have the lowest nursing standard for nursing homes in the western world. The Ontario government, despite promises made by Dalton McGuinty prior to the 2003 provincial election, refuses to establish a standard of quality care that nursing homes must provide each resident.

Since the McGuinty government came into office, there have been no significant increases to nursing home staffing levels, save for an increase in registered nurses. The Ontario government promised a revolution of change to Ontario's nursing home industry. What nursing home residents get is more of the same old regime. The Ontario government's lack of action in developing any standards for a minimum number of care hours nursing home operators must provide is nothing short of scandalous, and in my view it's immoral.

Prior to the last provincial election, SEIU asked the following questions. I'd like to point out these questions and Dalton McGuinty's responses.



The question was, "Will your government make public the number of care hours nursing home residents receive on a daily basis, for each Ontario nursing home?" The answer: "Ontario Liberals are committed to ensuring that nursing home residents receive more personal care each day. We will invest over \$400 million to increase the level of care in nursing homes and reinstate minimum standards."

Next question: "Will your government establish a minimum number of care hours nursing home residents must receive on a daily basis? If so what should the number of care hours per day be?"

"Yes. Ontario Liberals are committed to reinstating the standards of care for nursing homes that were removed by the Harris government, including a minimum 2.25 hours of nursing care daily and three baths per week," was the answer.

A year after taking government, here is what George Smitherman responded to questions at the standing committee on estimates. Ms. Martel asked, "Are you going to reinstate the 2.25" hours of care?"

"*Hon. Mr. Smitherman:* I answered the question yesterday, directly, and I'm pleased to answer it again.

"*Ms. Martel:* Okay, let me just confirm again. Are you going—

"*Hon. Mr. Smitherman:* No.

"*Ms. Martel:* So in fact you don't have any intention of keeping the promise you made in your election document, even though you were quite critical of the former government for cancelling the 2.25 hours of nursing care."

Moreover, the Liberal government has failed to deliver on funding by \$3,500 per resident annually to fulfill yet another 2003 election promise to increase nursing home funding to \$6,000 per resident annually.

I'd like to refer to the brief we've handed out, on page 6, where it says the crucial issue for this legislation must be the inclusion of a care standard. Every other jurisdiction in the western world is adopting minimum care standards. My question is, why not Ontario?

There is wide support in the literature that suggests minimum staffing levels ensure better quality care. Dr. Robyn Stone says, "Front-line workers such as nursing assistants, home care aides, and personal support workers are the centerpiece of a long-term-care system.... They are the 'eyes and ears' of the care system....

"Inadequate staffing levels diminish quality care....

"The consequences of inadequate staffing levels and poor training are:

"—diminished quality of care;

"—high turnover;

"—poor job quality;

"—abuse and neglect;

"—higher rates of injury to staff and clients."

Nancy-Ann DeParle says, "Our findings to date show a strong association between staffing levels and quality care.... The findings demonstrate that there are significantly more problems in facilities with less than 12 minutes of registered nursing care, less than 45 minutes

of total licensed staff care, and less than two hours of nursing aide care per resident per day." This is a total of 2.95 hours of care per day. In no nursing home SEIU surveyed was this standard anywhere near to being met.

DeParle contracted research firms and gathered data from 1,786 nursing homes in three states. Her recommendation for daily care came out as follows: Suggested minimum staffing is 2.95 hours per day; the preferred minimum is 3.45 hours of care per day.

A conference on nursing home staffing in April 1998 at New York University recommended that a proposed minimum total number of direct nursing care staff be 4.13 hours of care per resident per day, and that the total hours of care, including administrative and direct and indirect nursing hours, be 4.55 hours of care per day.

A United States study commissioned by the federal Centers for Medicare and Medicaid Services identified three staffing thresholds below which the quality of care was found to suffer. The threshold is 45 minutes for RNs; one hour, 18 minutes for total licensed services—RNs plus LPNs; and two hours, 48 minutes for certified nurse assistants. Any nursing home that meets these standards would provide at least four hours, six minutes of total nursing care per day. Thirty-six US states have adopted minimum standards of care. Some of those standards include: in California, 3.2 hours; Vermont, three hours; Ohio, 2.75 hours; Illinois, 2.5 hours; Florida, 3.6 hours.

I'd like to refer you to page 8 of the brief. You are already familiar with the PricewaterhouseCoopers study so eloquently cited by Liberal MPPs when they were in opposition. Again, the study points out that Ontario has the lowest standard in the western world. SEIU data shows most nursing homes are still below the 2.25 standard eliminated by the last government.

#### 1010

Page 9 of the brief: According to Online Survey Certification and Reporting, a data network maintained by the Centers for Medicare and Medicaid Services in the United States, total staff hours per resident per day in 2004 averaged 3.6. Nova Scotia's Department of Health has set targets when establishing approved facility staffing budgets: 3.25 hours of care for level II nursing homes.

William F. Benson, president of the National Citizens' Coalition for Nursing Home Reform, at a White House Conference on Aging in 2004 said, "Staffing is the primary issue that determines the quality of all of long-term care ... a minimum staffing level is absolutely essential to ensuring that basic care is provided to residents."

The Toronto Star, in an editorial in October 2006, had this to say about the new Long-Term Care Homes Act: "Without such a [minimum] standard, other efforts to improve care and curb problems will almost certainly fall short. How can neglect be stopped if nursing homes are not required to hire enough workers to ensure adequate care? How can abuse be ended if harried workers are too busy to notice?.... Smitherman said this week he has not set a minimum level of care because it would encourage staff to 'treat people like widgets.'"



Smitherman's view has done exactly that. He has treated people as commodities rather than real people with real needs.

A coroner's jury report in May 2005, in the inquest into the death of two nursing home residents in June 2001, made 85 recommendations to improve nursing home standards. The Ministry of Health and Long-Term Care responses to these recommendations in July 2006 indicated that the Ontario government will not make the changes to the care nursing home residents receive. Liberal promises for better standards remain broken.

For example, the coroner's jury recommendation 29 calls on the MOHLTC, pending an evidence-based study, to fund and set standards requiring long-term-care facilities to increase levels to, on average, no less than 0.59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case mix measure. The funding formula must be immediately adjusted to reflect this minimum staffing standard.

The ministry's response to the coroner's jury recommendation that at a minimum the care hours in Ontario nursing homes are comparable to similar jurisdictions is, as the international data shows, simply not true.

In a response to a petition presented to the Legislative Assembly of Ontario in the fall of 2006, the McGuinty government now says it believes that every resident's needs have to be assessed and that a legislated care level would not be responsive to a resident's changing needs. Does this government really believe that private nursing home operators will allow their front-line workers to make a decision on the level of care a resident will receive?

In the middle of page 6, understaffing equals poor resident care: In a membership survey conducted by SEIU last fall, 69% of nursing home workers indicated their workloads had increased over the past three years. Overall, they estimated their workload had increased by 36%. That's a result of the workload and the levels of care that these people are providing in the nursing homes as they exist today.

This government has lauded the fact that it has introduced patient lifts in every nursing home. While this is true, SEIU nursing home members report that it takes at least 10 minutes to find another staff member to help lift that patient because those lifts require two people to operate.

This government prides itself on the fact that it increased resident baths from one to two per week, ignoring its election pledge that it would institute three baths per week. Even now, our members report that residents always or sometimes—at least 30%—miss their second weekly bath.

Smaller nursing homes laid off other caregivers so they could accommodate the new 24-hour-RN regulation.

The typical situations nursing home workers experience daily show—

**The Vice-Chair:** You have one minute left.

**Ms. Stewart:**—thank you—show the urgent need for increased staffing. Local 1 members responded to a survey about patient care and staffing.

I want to touch on a couple of our many amendments for nursing homes in the remaining minute that I have.

Section 72: Amend to read, "That in order to provide a stable and consistent workforce and to improve the continuity of care to residents, every licensee of a long-term-care home shall ensure there is a staffing ratio of not less than 75% full-time and 25% part-time. No nursing home licensee shall allow the nursing staff or resident ratio to fall below 3.5 hours of care per resident per day."

Accountability: The Minister of Health and Long-Term Care has indeed established a public reporting on long-term-care homes; however, the information is dated. The data includes only information from the current reporting period, which means it will be at least six months old and could be as old as eight or nine months.

**The Vice-Chair:** Thank you very much for the presentation. There's no time left.

#### CONCERNED FRIENDS OF ONTARIO CITIZENS IN CARE FACILITIES

**The Vice-Chair:** The next presentation will be by Concerned Friends of Ontario Citizens in Care Facilities. Please state your names for Hansard, if you don't mind. You can start when you are ready.

**Ms. Freda Hannah:** Freda Hannah.

**Ms. Lois Dent:** Lois Dent. We're representing Concerned Friends of Ontario Citizens in Care Facilities, which is a volunteer advocacy group that has been dedicated to improving the quality of care for residents in long-term-care homes for over 25 years. The work of Concerned Friends is done by volunteers and supported by membership fees and donations.

The board of directors of Concerned Friends appreciates this opportunity to present our comments and recommendations on Bill 140 to the standing committee on social policy.

We are pleased with the spirit of this act. We find that it is resident-focused, has an expanded and strengthened bill of rights, detailed provisions on the prevention of abuse and neglect, and limits on the use of restraints. We welcome and support many provisions in the act, such as the graduated sanctions, significant financial penalties assessed against anyone convicted of an offence under the act, and the definition of a secure unit as a restraint if the resident cannot exit from the unit independently.

The section on the plan of care outlines clearly what must be included in the plan, and also details the documentation required. These provisions will help to ensure high-quality and consistent care. However, because accurate and concise documentation requires both time and skill, the Ministry of Health and Long-Term Care must ensure that homes have sufficient qualified staff to effectively carry out this essential function.



The protection of residents from abuse and neglect is strengthened through zero tolerance policies, mandatory reporting requirements and whistle-blowing protection. We hope these protections, especially the whistle-blower protection, will prove to be effective, as the fear of retaliation has long been a deterrent to the reporting of incidents of neglect and abuse.

Given the present variety of venues available for obtaining information—such as the long-term-care hotline, the Public Reporting on Long-Term Care Homes website, compliance advisers and community care access centres—we do not see a need for the establishment of an Office of the Long-Term Care Homes Resident and Family Adviser, as described in this act. We are also concerned that the duties of this office are open-ended and could be expanded to include the powers and costs of a long-term-care-homes ombudsman. If such a position is created, we believe that the ombudsman's responsibilities should encompass all aspects of elder health care, and that such an office must be independent from the Ministry of Health and Long-Term Care.

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The act helps to empower family councils and ensure that they will have an important role in the life of the long-term-care home. It obligates the licensee to advise families of their right to establish a family council if one does not exist. The act states that a family member of a resident, a former resident, or a person of importance to a resident or former resident may be a family council member.

It also allows a person who lives in the community where the long-term-care home is located to be a member of the family council. We do not see the benefit in having someone from the community who has no connection, past or present, with any resident as a member of the family council, and we have some concern that adding this category of membership could lead to potential difficulties for the family council. For example, the motivation of a community member may be completely at odds with the educational/informational directions and immediate concerns of family members or friends of residents. The family council would certainly be able to invite interested members of the community to attend meetings and assist in various ways, but they would not have the same rights and privileges as a family member or a friend.

The act lists 10 powers that family councils may exercise, including the power to "attempt to resolve disputes between the licensee and residents." We believe that this responsibility is better left to the residents' councils, and that family councils should have the power to seek solutions for areas of concern between the licensee and families.

We support the section of the act requiring the licensee to prepare a package of information for every new resident and make it available to family members and persons of importance. This very comprehensive package is to include information about the family council, if any, or, if there is no family council, any infor-

mation provided in the regulations. We recommend that the regulations inform families that there are resources available to them for assistance in developing and sustaining a family council. The information on family councils should also note that the benefits of family councils include mutual support, information and education, as well as advocacy.

Limits to the use of agency and temporary staff are important and will improve the consistency and overall quality of care. The requirement that staff providing direct care to residents must receive additional training in caring for people with dementia and managing aggressive behaviours is critical to ensuring good care. We recommend that training to improve the cultural competency of staff also be included. We expect the regulations will spell out in more detail what the training must include and how it will be undertaken. We also look forward to details about the qualifications that staff will be required to have.

We recognize that the education standards for personal support workers have improved in recent years. However, as far as we are aware, it is still not a requirement that all personal support workers complete the course of study before being hired. We urge that the ministry make it mandatory for personal support workers, who provide the majority of hands-on care to residents, to complete a certified, government-approved personal support worker course before being hired to work in a long-term-care home.

The act states that there may be regulations related to the use of psychotropic drugs, including requiring that the home discuss the use of such drugs with the medical director. We believe that the role of the pharmacist should also be considered and include overseeing the safe use of these and other drugs, as well as the interactions among medications already prescribed for the resident. We also recommend that the act contain provisions to ensure that the medical director and the physicians providing care to residents in the home have previous experience in treating elderly people with complex care issues or have some training in geriatric principles.

The act includes an amendment to the Coroners Act that requires the coroner to be notified of the death of every resident in a long-term-care home. It will then be up to the coroner to decide whether or not the death should be investigated. This is an important safeguard. We recommend an added provision that prohibits coroners from being employed as physicians in long-term-care homes to avoid any potential conflict of interest.

Concerned Friends regrets that this legislation does not respond to the urgent need for specialized units in designated long-term-care homes to care for residents with serious behavioural problems. As recommended by the jury for the Casa Verde inquest, these units should include short-stay beds for assessment and development of appropriate care plans; longer-stay beds to allow for the implementation of the care plan; and, where necessary, beds allotted for the long-term stay of residents who



need to continue to be cared for in such specialized units. This is a serious omission that must be rectified.

The Ministry of Health and Long-Term Care has chosen not to include a minimum standard of care—hours of nursing and personal care per resident per day—in this act, yet adequate staffing to meet the increasingly complex care needs of residents is fundamental to the successful implementation of many of the provisions of this act.

While a minimum standard of care is one way to ensure adequate staffing, we believe there are better methods. The ministry is currently piloting the adoption of the long-term-care assessment tool—the minimum data system—resident assessment instrument, MDS—RAI—for assessment and care planning in homes across the province. We recommend that this process be speeded up and used as the basis of a new funding system. We need a responsive funding system that is based on the actual needs of residents, not an arbitrary minimum number of hours of care. As well, the public has a right to information about each home's staffing levels. We suggest that this information be added to the home profile on the public reporting website.

In conclusion, Concerned Friends is aware that a lot of hard work and careful consideration have gone into the drafting of this very comprehensive act. It has been a long time coming. Although we believe the act will benefit from some adjustments, we look forward to its implementation.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left, one minute for each party. We'll start with Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. I found it really quite interesting. I think you've made some excellent recommendations. The point about the need for the personal support workers to receive some programming and education is, I think, an important one.

Just a question about your organization: Are you primarily Toronto-based or do you have representation across the province of Ontario?

**Ms. Dent:** We have some representation across the province, yes.

**Mrs. Witmer:** Okay. So what you've gathered here is from all of those individuals?

**Ms. Dent:** It comes a lot from the calls that we receive. We get calls from people from across the province. Certainly, more of them are in the GTA than, say, Thunder Bay, but it does represent our members across the province.

**Mrs. Witmer:** Thank you very much.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you very much for your presentation today. I notice that you said we don't need the Office of the Long-Term Care Homes Resident and Family Adviser. So you think that should be deleted from the legislation?

**Ms. Dent:** I think it could be, yes.

**Ms. Martel:** As I understand it, your organization is part of the seniors' advisory committee on long-term care.

**Ms. Dent:** Yes, we have a representative there.

**Ms. Martel:** You're signatories to a letter that went to Ministers Smitherman and Bradley in August 2005 recommending an independent ombudsman. Can you give the committee the reason why you think an independent ombudsman, or perhaps having the current Ombudsman have oversight, is an important change that should be implemented?

**Ms. Dent:** Yes, we were signatories to that letter. However, there was a lot of back and forth about what the ombudsman's responsibilities should be. It definitely should be independent, because how else can an ombudsman really carry out their duties? He or she should report directly to the Legislature, as the current Ombudsman does, but it should be encompassing all health, not just long-term care.

**The Vice-Chair:** Thank you, Ms. Martel. Parliamentary Assistant?

**Ms. Smith:** I just want to take this opportunity to thank both of you, Lois and Freda, for all of your help and work. As the other committee members may or may not know, these two women have come out to every advisory meeting that we've had on the legislation moving forward. So I want to thank you for the input that you've given and again for appearing today and providing us with yet a little bit more.

I just wanted to have you expand for a moment on your views around family councils and the need or lack of need for having community members. Why do you see that as a downside for the structure of family councils?

**Ms. Dent:** Well, as we tried to say in there, we don't see any benefit from it because the whole focus of a family council is to work with a home regarding improving the quality of care of the residents. We're not sure what a community person would add, and potentially they might—why would they be interested? Maybe they just want to help out or—I hate to say this, but they might have some other reasons for wanting to have some influence. It's just a potential concern, but I don't see any upside. I can't see any benefit from it, and I can see potentially a problem.

1030

**The Vice-Chair:** Thank you very much for your presentation.

#### ONTARIO LONG TERM CARE ASSOCIATION

**The Vice-Chair:** The next presentation will be by the Ontario Long Term Care Association. Can you please, before you start, state your name for the Hansard?

**Ms. Karen Sullivan:** Sure. I'm Karen Sullivan. I'm the executive director of the Ontario Long Term Care Association.

**Mr. Bill Dillane:** I'm Bill Dillane. I'm president of the Ontario Long Term Care Association.



**Mr. Brent Binions:** I'm Brent Binions, vice-president, financial liaison, OLTCA.

**Ms. Sullivan:** We're here on behalf of our members, who operate 430 long-term-care homes, where 50,000 of Ontario's oldest and frailest citizens live, to ask you to remove the uncertainty that Bill 140 creates for their future, to strengthen its ability to provide the care and services that residents need and to increase long-term-care homes' ability to be a system solution.

We support the bill's strengthened provisions for resident safety, abuse prevention and whistle-blower protection. We are deeply concerned, and in some instances puzzled, that Bill 140 contains many other provisions that will create uncertainty, focus on paperwork at the expense of care, foster institutionalization, and set homes up for failure.

Committee members will know that our concerns are also shared by residents, families, staff, communities and others. We have developed 95 amendments that we believe are required to address the issues in Bill 140, and we will provide these to you by January 19. Today I want to focus on the two critical issue themes: uncertainty for existing homes and risk to care and services, both of which also impact the broader health care system.

It is disappointing that while this legislation took three years to write, it will introduce limited-term operating licences linked solely to the building's structure without a plan to reassure communities that there will be homes to meet increasing demand or that these homes can meet resident expectations for privacy and dignity. The plan is apparently an afterthought.

But without this plan, sections 100 and 180 will start the clock of uncertainty ticking for all homes the day this bill is passed. This clock will tick the loudest for 263 C class homes, many in small rural communities. Their operators, families, staff and 27,500 residents will be left wondering what day in the next seven years the ministry will decide to reveal their future. The options include: close the home, close some of the beds, rebuild—which is impossible without a capital renewal program, invest millions in upgrades and still leave three- and four-bed wards, or renew the licence with no changes, again perpetuating three- and four-bed ward accommodation.

Even if a home meets government's renewal terms, Bill 140 doesn't identify the length of a new licence term. Apparently it could be different for different operators or homes. The worst option is hearing nothing in seven years. Ministry silence means the home will close, and subsection 101(5) allows them to not explain their decision to anyone.

This is hardly reassuring for any community, particularly since many, like Kingston, Sudbury and Niagara, are struggling with shortages of long-term-care beds. It hardly reassures residents, families and staff over the future of their home, their care or their job. They also do not understand why the government does not provide capital funding so that residents can live in homes that provide the privacy and dignity that government is helping fund for residents in newer and rebuilt homes, particularly when all residents pay the same.

Operators will see their financing terms change and find it increasingly difficult to finance home maintenance and upgrades. For smaller operators, it is enough uncertainty to threaten their future in the sector.

We have developed a more workable solution that meets what we believe are the government's objectives, but replaces threat and uncertainty with predictability and stability. It will allow government to introduce limited-term licences and recognizes that these licences should not be perpetual. It also recognizes that community bed demand, operator performance and building structure should determine license renewals.

Most importantly, our solution provides the action plan for Ontario to move forward with the rest of Canada in eliminating three- and four-bed ward rooms in all homes over the initial licence term. It defines what happens after the initial term expires, which is essential for stability and financing, and it supports maintaining structural integrity on an ongoing basis.

We ask that you support this solution by amending subsection 180(3) to provide B and C homes with initial fixed-term licences of 15 years and to empower government to fund a capital renewal and retrofit program. Government must then act on its support for Elizabeth Witmer's motion by committing to work with the sector to immediately develop this program. This would enable the sector to rebuild or retrofit 2,500 beds per year, which is the approximate number of D beds that were rebuilt annually, and renew all B and C homes over those 15 years. This licence term matches the current average amortization period for these homes, thus eliminating much of the instability from the proposed 10- and 12-year terms. Homes would have to meet this deadline for their licence to be renewed. Homes would then receive a 25-year licence. In some cases, retrofitting would make more sense for eliminating three- and four-bed wards and would reduce capital program costs.

The Canadian experience, and Ontario's D bed rebuild program, demonstrate that successful structural renewal requires a plan that includes design standards, capital funding and operator deadlines. Ontario can begin building a major success story with commitments in place and details worked out over the next six months. Actual funding would not have to flow until the first rebuilt or retrofitted homes open in 2009.

To provide predictability for government, homes and communities, we ask that section 100, subsections (1) to (3), be amended to provide 10-year licence terms at the end of the 25-year term, with renewal subject to the operator demonstrating a demand for the beds, a solid compliance record and that structurally the home meets residents' needs. A commitment to work with the sector on a jointly funded asset management program would help ensure that the latter is not an issue.

I now want to focus on how Bill 140 fails to meet enhanced care and service expectations, specifically some of the sections that, if not amended, will put existing care and service levels at risk and make homes more institutional.



Bill 140 requires additional paperwork and processes that will reduce the already insufficient time available for resident care. A new doctrine of absolute compliance will force homes to comply, as inspectors will have no choice but to formally ticket homes for every compliance infraction they see, even something like a cup of tea that is spilled during lunch and wiped up a minute later. The impact will not only breed a culture of blame and shame but more paperwork and processes to track and document compliance issues, irrespective of the effectiveness of these requirements for enhancing care delivery.

For example, under paragraph 5 of subsection 28(1), any resident who cannot enter the outside door lock code will be deemed to be restrained. Ministry standards require these locks to protect the over 60% of residents affected by dementia. Now the home itself will be considered a restraint, requiring homes to implement the increased monitoring and other provisions as outlined in subsection 28(5) for some 45,000 residents. With the new public reporting requirement for the number of residents restrained, Ontario is ensuring that it will have the worst resident restraint record by far.

Further, subsection 18(3) requires that anyone entering the home to do work has a copy of the home's abuse policy first. To demonstrate compliance, homes will need processes that document that everyone from the ambulance attendant to the newspaper carrier has received the policy before they come in the door.

We ask you to amend these and other sections, as outlined in our detailed submission, to be more realistically implemented while still enabling government to effectively monitor homes.

We also ask you to amend sections 150 to 154, dealing with graduated sanctions. Although we support their principle to enhance resident care and safety, two issues need to be addressed. Firstly, it is not a truly graduated process, because inspectors can apply whatever remedy they want to any situation. Secondly, they will have unfettered authority to issue work and activity orders for everything from staffing to building renovations, without reference to ministry funding or a home's financial capacity. Bill 140 will legislate that lack of government funding is not grounds for appeal, and if a home cannot comply, government will have the authority to withhold or claw back the home's funding.

How is it appropriate that when government funds nursing care, and the home spends it all for this purpose, the government can then order them to add more staff? This absolute power will see care and accommodation standards increasingly being set by work and activity orders, and these standards will vary from region to region and home to home. Further, we fail to understand how reducing funding will benefit residents if a home is non-compliant.

1040

We urge you to amend sections 150 to 154 to provide a predictable and consistent sanctions framework, and to replace work and activity orders and financial penalties with more resident-sensitive remedies. These would in-

clude the power to impose external managers at the operator's expense.

Funding is a core issue and, admittedly, primarily a budget issue. Bill 140, however, does have significant funding implications for the ability of homes to meet its requirements. Most glaring are sections 8 and 9, which require homes to provide restorative care and recreational and social activity programs to meet individual assessed resident needs. We want to do this, but we know we will fail because it is impossible when government funds about 2.5 hours of nursing care a day and three hours or more are required, and only provides \$6.82 per resident per day for all activation, social work and therapy services.

At the same time, government is eliminating its commitment to fund what Bill 140 requires. The reference to this commitment in subsection 88(1) contains the wording "may fund." Existing legislation contains the commitment "shall fund."

I want to conclude with a comment on Bill 140's implications for system issues such as the hospital bed shortages created when hospitals cannot discharge alternative-level-of-care patients to long-term care. You likely are aware that the Kingston General Hospital may now start charging those patients \$800 per day. This is a complex issue, and the solution is larger than building more beds. It also requires measures that provide a strong, stable and effective long-term-care sector that is there to meet the needs of the community, including transferring people out of expensive hospital beds.

Instead, however, Bill 140 is creating huge uncertainty, diverting our limited staff to undertake more paperwork and making us accountable to do more, with no commitment to funding. At a time when it is becoming increasingly difficult to recruit and retain staff, we are creating a culture of blame and shame with Bill 140 that makes our sector less and less attractive to staff.

Please help us so that we are there for our hospitals, for our communities and for our seniors by making these important amendments to Bill 140 and committing to a plan for capital renewal.

Thank you for your time this morning.

**The Vice-Chair:** Thank you for your presentation. We have three minutes left. We can divide them equally among the three parties, with Ms. Martel first.

**Ms. Martel:** Thank you for your presentation today. The draft white paper asked questions about licensing. Can I ask what your association put forward at that time? Subsequently, after you did that, what kind of discussions did you have with the government with respect to proposals around licensing, if any?

**Ms. Sullivan:** We would have preferred to have our licences based on compliance with the legislation as it is now, a yearly licence, and we asked for a capital renewal program as well as an asset management program to set aside money so that we keep our homes up. We've now submitted an amendment to try to work within their fixed-term licence principle and still have some certainty within the sector so that we can ensure that homes are



there to meet the needs of communities, which we're very concerned about with the current—

**The Vice-Chair:** Thank you. The parliamentary assistant.

**Ms. Smith:** Karen, you will acknowledge that we do have an RFP out in Kingston and Sudbury and in a number—I think 10 in total—of communities across the province for new beds to address some of the shortages that you discussed, right?

**Ms. Sullivan:** You do, yes.

**Ms. Smith:** Also, I just wanted to ask you—on page 10, you talk about the “absolute power that will see care and accommodation standards increasingly being set by work and activity orders.” Can you expand on that and your view that this will create standards that vary from region to region?

**Ms. Sullivan:** We're concerned that an activity order could be, “You need to add more staff,” and if we're spending all of our nursing envelope, which is the funding that you give us, and an inspector can say—they attempt to do that now. They come to our homes and say, “We want you to add a shift in the night, because we see that you need more care,” except that we're spending all of our nursing envelope; we don't have additional money to spend. So we're concerned we're going to get those types of activity orders in the homes based on that piece of the law.

**The Vice-Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much. I certainly can understand your concern, and I think the RFPs the government is talking about have just gone out now. The reality is, there's a huge problem in our acute care hospitals with people looking for alternative placements, including long-term care, and the government up until now has had absolutely no capital renewal plan. Unfortunately, this bill as currently written really does endanger even more the certainty of people who need long-term care being able to access a facility in a timely manner. I appreciate the compromise that you've put forward to the government regarding that requirement.

I guess the other issue that you're very concerned about, and we've certainly heard that as well, is the environment that's being created by some of this legislation and the impact it's going to have on staffing. We heard from the physicians this morning and I think you've indicated as well that it may become somewhat difficult to have the staff that is going to be required with some of the punitive measures and enforcement measures. Can you speak to that a little bit more?

**The Vice-Chair:** Sorry. Thank you very much; we don't have enough time. My apology.

#### ONTARIO STROKE SYSTEM

**The Vice-Chair:** The next presentation will be by the West Greater Toronto Area Stroke Network. Welcome. You can start whenever you're ready.

**Ms. Nadia Hladin:** Good morning. My name is Nadia Hladin and I am representing the Ontario Stroke System.

I'd like to express my appreciation and that of the Ontario Stroke System for the opportunity to provide input on this important legislation.

We are pleased to offer our advice and input to the Ontario government, particularly when we see that the government is moving in the right direction to improve our health care and long-term-care systems. However, our positive comments must be mixed with some cautions and constructive criticism. While we are pleased to see that the legislation attempts to clarify and protect the rights of long-term-care residents, Bill 140 does need some amendment to reach some of these goals.

Before we outline the problems we see and the solutions we suggest, let me provide some information about the Ontario Stroke System.

In 2000, following a three-year demonstration phase led by the Heart and Stroke Foundation of Ontario, the government of Ontario released Towards an Integrated Stroke Strategy. This report, prepared by a joint Ministry of Health and Long-Term Care and Heart and Stroke Foundation work group, outlined a comprehensive strategy to improve access to best possible stroke care.

There are now 11 regional steering committees developing and implementing regional plans for effective stroke care across the full continuum from prevention to long-term care. A provincial steering committee identifies and responds to province-wide issues and fosters collaboration. I am the chair of the rehabilitation and community engagement subcommittee of the provincial steering committee.

The Ontario Stroke System work with respect to long-term care includes the following:

(1) The development of best-practice guidelines. Our guidelines cover the complete care continuum.

(2) We recognized the importance of educating and supporting personal support workers in long-term-care homes. We developed the Tips and Tools resource, which we would be happy to share with you.

(3) Each region has a community and long-term-care specialist who is supporting collaborative work to address the needs of stroke survivors in their own homes, including long-term-care homes.

The Ontario Stroke System has a strong interest in health care legislation affecting the elderly because of the large role that stroke plays in that segment of the population. Stroke is the leading cause of disability in elderly people, affecting 85% of stroke survivors in their daily lives. In fact, over the age of 65, stroke is more common than heart attack, especially in women.

Despite our best efforts, this is expected to be a growing problem. The aging population and longer lifespans are making stroke more common. The residual effects of stroke can be very serious, not only limiting people physically, but affecting their ability to think, communicate, perceive, sense, and connect to others on an emotional or social level. The after-effects sometimes include depression and dementia. Not surprisingly, the caregivers of stroke victims are often deeply affected.

The good news is that a growing body of research is validating the important role played by rehabilitation of the victims of stroke. While the first 12 weeks usually see the biggest motor improvements, research is showing that patients can continue to improve as much as two years later, and those improvements can be sustained in the long term.

1050

Rehabilitative therapy is vital to improving victims' rate of recovery, their functional outcomes and the quality of life. Just as importantly, rehabilitation programs reduce morbidity and mortality rates. In short, rehab saves and improves lives.

We are very pleased to see that the patients' right to receive restorative care that promotes and maximizes their independence is written into this legislation; however, we are concerned that the term "restorative" is not defined anywhere in the legislation. As I am sure members of this committee can appreciate, failure to spell things out in legislation can lead to confusion and misinterpretation down the road. While physiotherapy is now available in many long-term-care homes, there are other types of services and therapies that could, and should, qualify as restorative. Those rehabilitation options should be spelled out in the legislation, providing a specific meaning to "restorative" in Bill 140. This list should include not only physiotherapy but occupational therapy, speech language pathology and social work. This would ensure that residents benefit from the clear intent of the bill, which specifies that a plan of care created by a licensee should cover "all aspects of care."

This brings us to what the Ontario Stroke System sees as the most important area of needed improvement in Bill 140: the need to match resources with intent. For example, it is wonderful to state, as this legislation does, that every long-term-care home should have an organized program of restorative care. It is even better to state, as Bill 140 does, that those programs must meet the assessed needs of residents and aim at promoting the greatest possible independence. However, who will make those assessments of those residents' needs? Who will decide what services or therapies will best promote their independence? Obviously, to meet the stated goals of the legislation, those decisions should be based on professional opinions, using solid evidence and best practices. Only then can we be certain that the best interests of residents are being served.

It follows that rehabilitation professionals working in or for long-term-care homes should have demonstrated knowledge and expertise to appropriately assess and treat the residents. And once the right professionals have decided upon the right care, we must make sure that residents have access to that care. There is no point in making expert assessments and designing perfect care plans if the residents are left on waiting lists or simply do not receive the services they need.

This is where the Ontario Stroke System believes that flexibility must be built into the legislation. Long-term-care facilities need flexibility to make the best use of

their limited resources, to minimize the bureaucracy and rules that might prevent giving the appropriate care. Again, we return to the principle here that residents deserve appropriate rehabilitation services that will improve their function, safety and quality of life. Let's make sure that Bill 140 does not inadvertently create barriers to care.

Long-term-care facilities should have the flexibility to offer specialized programs or services where there is sufficient demand and hope for helping residents. Pilot projects have found that these programs not only help residents but improve staff expertise and job satisfaction. For example, Castlerview Wychwood Towers in Toronto created a slow-stream rehab program for 40 residents who had survived severe strokes. At the end of the project, 16 of those residents were actually able to return home.

If a particular long-term-care facility cannot provide what, in expert opinion, is needed, then residents should have the ability to access services in the broader community. I want to quote directly from the preamble to Bill 140, where it states that the people of Ontario "strongly support collaboration amongst residents, their families and friends, service providers, caregivers, volunteers, the community and governments, to ensure that the services provided meet the needs of the resident."

The Ontario Stroke System agrees that collaboration is necessary to meet the goals. It will also be necessary to provide sufficient funding and resources so that access in real life matches the principle of the legislation.

Our evaluation report of the Ontario Stroke System, released last October, found that only 24% of acute stroke sufferers access in-patient rehab. The most severely affected stroke clients are not being treated in hospitals but are being discharged home or to long-term-care facilities.

In fact, nearly one quarter of all people suffering a stroke go directly to a long-term care facility after an acute hospital admission. What's interesting here is that in 2001, it was 8.9%. We did stats for 2005, and it was 22%. So it has gone up significantly in a four-year period of time.

Long-term-care facilities are rapidly becoming key stroke treatment centres. Our Ontario Stroke System evaluation report found that more than 19% of all long-term-care residents are stroke survivors. We need to make sure that they are getting the rehabilitative care they need, either in those homes or in the community. Yes, there is a cost to providing that level of care, but it is actually less than the cost of not providing that care. Access to appropriate rehab services early on actually decreases health care costs in long-term care.

This commonsense conclusion is backed by many studies, such as the geriatric rehab study conducted in long-term-care facilities in Alberta in 1996. It demonstrated reduced nursing costs due to reduced care needs where rehab services were optimized in a long-term-care setting.

Closer to home, a pilot study in the southwestern Ontario stroke region found that individuals with severe



stroke benefited from outpatient services. Thanks to the extra treatment, 43% more survivors of severe stroke were discharged back to their homes and 38% fewer were discharged to long-term-care facilities. Those numbers add up to real savings for the health care system and real improvements in the lives of stroke victims and their families.

Even for those residents who do go to a long-term-care home, those who have been given rehab treatments tend to need less staff intervention and support. Again, this results in both savings and better health outcomes.

The committee should consider how funding formulas could be changed to reward long-term-care homes for enhancing independence instead of encouraging dependence on staff.

I want to leave some time for questions, so let me conclude by congratulating the government on recognizing the important principle of access to restorative care and by urging the government to ensure that this principle is upheld in action and in the future by amending the bill.

Once again, I thank you for this opportunity.

**The Vice-Chair:** We have two minutes left. Mrs. Sandals.

**Mrs. Liz Sandals (Guelph-Wellington):** Thank you very much for your presentation. I have a very active stroke group in Guelph, and they've shared their concern around rehabilitation with me.

I'm intrigued by your concluding comment about considering how funding formulas could be changed to reward long-term care. You've talked about all the non-nursing supports that your stroke victims would benefit from. I'm wondering how you would see the funding formula rewarding access to those other services which I think you feel are really crucial for your folks.

**Ms. Hladin:** Our thoughts are that now the funding formulas are based on the amount of nursing care—the heavier the care, the more funding they receive—so it prevents people from wanting their residents to become more independent, because they will receive less funding. There should be a shift in the dollars to encourage independence and provide other programming etc. that they can participate in to offset the nursing costs.

**The Vice-Chair:** We don't have enough time for the other parties. Thank you very much for your presentation.

1100

## ONTARIO MEDICAL ASSOCIATION

**The Vice-Chair:** Next is the Ontario Medical Association. You can start whenever you're ready.

**Dr. David Bach:** I am David Bach, president of the Ontario Medical Association and a radiologist in London, Ontario. With me on my right is Stephen Chris, the chair of the OMA working group on long-term care and a family doctor in Toronto, whose medical practice is dedicated to long-term care. On my left is Ms. Barb LeBlanc, the executive director of health policy at the Ontario Medical Association.

I would like to begin by commending the government for moving forward to consolidate the statutes that currently govern various types of long-term-care facilities. Having one act instead of four will bring much-needed clarity and consistency to the field.

Although I believe Bill 140 to be well-intentioned, it appears from the physician perspective to have two fundamental flaws. First, it does not reflect the reality of the medical condition of the average nursing home resident. Second, it seems to reflect a belief that the challenges in the nursing home sector can be resolved by the imposition of rigid rules and harsh punishments upon those who work in the field. There is now abundant evidence, drawn from many disciplines, demonstrating that this is not a successful strategy for system improvement, and we do not believe it will be successful in this environment either.

The general thread running through Bill 140 is one of mistrust of everyone who operates or works within a long-term-care home. In truth, the current problem with long-term care is primarily due to inadequate funding, as you've heard earlier. Despite this, quality health care services are delivered to long-term-care residents owing to the care and dedication of long-term-care staff. We will not discuss the funding issues further this morning, but it remains a significant problem.

A paternalistic and suspicious attitude manifests itself in numerous ways throughout the legislation, but is seen most vividly in the proposed mandatory reporting requirements. The act would impose a duty upon all persons coming into the home to report any perceived abuse, neglect, improper or incompetent care, or even a suspicion of any of these things, to a government civil servant. The implication here is that the staff in the long-term-care homes are non-caring, incompetent or ruthless, and therefore in need of intense monitoring. This flies in the face of the entire patient safety movement and its shift away from "naming, blaming and shaming" towards looking at means to improve processes and systems. Given this government's stated commitment to patient safety, it is discouraging to see a potentially promising opportunity to embed these values into our long-term-care system lost.

We believe that Bill 140 should be amended to better reflect and utilize the current state of knowledge with regard to quality management and to reflect the government's stated commitment to advancing this philosophy. This would require a clear commitment in the legislation towards advancing continuing quality improvement within nursing homes.

Moving from the philosophical to the practical for a moment, we also worry that the proposed reporting system may result in overzealous reporting in light of the threat of \$25,000 or \$50,000 fines or even imprisonment. The OMA would rather see clear and focused reporting criteria that deal with sentinel events, coupled with a well-resourced government body to investigate and deal expeditiously with real problems.

We know that patient safety principles and individual accountability are not mutually exclusive. The patient

safety paradigm clearly supports action against individuals where there is malfeasance, abuse or genuine neglect. It recognizes, however, that most errors and omissions in complex systems, be they commercial air travel, nuclear power or health care systems, are the result of system failures, even when they manifest themselves in the action or inaction of a particular individual. The government's current compliance and inspection system is in no way prepared, either by philosophy or expertise, to deal with problems using patient safety tools, and indeed, as government agents, they are not the appropriate body to do so. The OMA recommends that the current government program remain in place to deal with serious events and allegations of abuse or neglect, but that other matters be addressed through a strengthened focus upon quality assurance within long-term-care homes.

I would now like to turn the microphone over to my colleague Dr. Stephen Chris to talk about the OMA's concerns about Bill 140's impact upon health care for residents of long-term-care homes.

**Dr. Stephen Chris:** Quality of life for the frail and vulnerable segment of our population living in long-term-care facilities is directly related to health, and it is essential that attention be given to issues around the care and treatment of nursing home residents, virtually all of whom have multiple health problems. The Ontario Medical Association calls upon government to commit to the health of our seniors by acknowledging, as a fundamental principle, that residents' health care needs will dictate the care and treatment they receive, including their placement within the home, as well as movement in and out of the home as their health status changes.

It is evident from the introductory paragraphs that Bill 140 has not been written with a view to improving the care provided to residents of long-term-care facilities, and the OMA finds this omission disturbing.

A commitment to care includes fundamental issues like safety for both individual residents and the residents as a whole. Preventing a home from moving a resident to a secure unit even with family consent, until such time as they have met with a rights adviser and, where requested, had a hearing before the Consent and Capacity Board, puts the safety of the individual at risk. Depending on the circumstances, the safety and security of other residents, as well as visitors and staff within the home, may also be placed at risk. While the OMA agrees that greater attention needs to be given to the utilization of restraints and secure units, we believe that the real problems in this area would be better addressed by means of expanded geriatric assessment services and better access to specialized geriatric behavioural treatment facilities.

The act does attempt to deal with the care of residents in the section relating to plans of care, but again, instead of creating an enabling environment to promote and enhance interprofessional care, the bill is prescriptive and bureaucratic. The OMA recommends that Bill 140 be amended to promote interprofessional care by means of shared input into each resident's overall care plan. Such

plans would be reviewed annually, or more often if required. There needs to be a distinction, however, between this broad plan and all of the detailed program- or discipline-specific plans that would fall under it. The treatment plan is one such subset, and although there are clearly some issues relating to a resident's medical status that are of general interest across programs within the facility, such as the onset of type 2 diabetes, there are other health matters that should not be widely shared, and the OMA strongly supports patients' rights to privacy as outlined by this government in the Personal Health Information Protection Act, 2004. We believe that the proposed plan-of-care provisions in Bill 140 need to be amended to support its practical application and to protect residents' rights.

Before turning the microphone back to Dr. Bach, I would like to conclude on a personal note. As a medical director at four homes in Toronto, I am responsible for the quality of medical care in these homes, and I have to say that I felt very discouraged reading this legislation. I am left with the feeling that the services of physicians are not valued, and I worry that others will have the same feeling. Why would I want to subject myself to a demeaning work environment where I am constantly worried about the possibility of being the subject of a frivolous or vexatious complaint? Why would my colleagues feel any differently? I am genuinely worried about the message that this legislation sends to physicians, and I hope that you will listen very carefully to our concerns. Thank you.

**Dr. Bach:** In our view, this bill, if unchanged, will represent as significant a failure of public policy as the decision to shrink medical school admissions over 10 years ago; that is, the consequences are not immediate but will be difficult and will be difficult to reverse once recognized.

I will close by saying that the OMA believes that Bill 140 would benefit from a review that places residents' health care needs on an equal footing with the various rights that are outlined in the act. From our perspective, the right to enjoy the best possible health is a fundamental human right and should be supported, not undermined, by government legislation.

In addition to our verbal comments today, the OMA has prepared a written submission which outlines a number of concrete areas for change. Although it is difficult to amend the tone of the legislation, we urge this committee to make amendments in key areas to make the bill less mean-spirited towards the dedicated people who work in an increasingly complex and difficult environment.

Thank you for your attention. We are pleased to take questions.

1110

**The Vice-Chair:** Thank you, Dr. Bach and Dr. Chris, for your presentation. Now we will open the questioning. You have about four minutes. We'll divide it between the two parties.

**Mrs. Witmer:** Thank you very much, Dr. Bach, for your presentation. Actually, it's quite concerning to see



the statements that you've made, particularly when you say this is going to be as significant a failure of public policy as the decision to shrink the medical school admission 10 years ago, and I think we are hearing this morning that the bill is mean-spirited and is naming, blaming and shaming the dedicated people who are working in the environment. That is of personal concern to me, and obviously other people. How can the government make specific amendments that would change that tone, and do they need to rewrite other parts of the bill in order that it reflects the need to move forward in a different manner?

**Dr. Chris:** Our written presentation goes over some of the specific sections that we think should be amended, but I agree that it is very difficult when the underlying tenor of the bill from beginning to end will create problems for staffing in homes. I would personally prefer to see the bill reviewed again with the input of all of those of us who will be affected in our day-to-day work.

**Mrs. Witmer:** Did you have input into this legislation already?

**Dr. Chris:** I don't believe we had input in the drafting process.

**Interjection:** Did you want to respond to that?

**The Vice-Chair:** Thank you very much.

**Interjection:** If we could—

**Ms. Martel:** If you just want to respond, and then I'll ask you my questions.

**Ms. Barb LeBlanc:** We were involved in the earlier consultation phases, but unfortunately, as we volunteered to have meetings with the government as they were drafting and pre-drafting, they did not choose to meet with us.

**Ms. Martel:** Thank you for your presentation today. You've mentioned amendments in two areas, and we don't have the written submission—at least I don't; maybe the others do—so maybe off the top you can tell us: One was an amendment to better reflect and utilize the current state of knowledge with regard to quality improvement, and the second area had to do with protecting residents' privacy rights. I wonder if you can just give us a flavour of the proposed changes.

**Dr. Chris:** The whole modern area of quality improvement in complex systems is a rapidly advancing area of knowledge. This bill uses the old-fashioned, almost mid-20th-century attitude of punishing people for errors, rather than looking at how errors can be used to improve the systems themselves. I think the OMA is proposing that there be quality improvement measures written into the bill.

**The Vice-Chair:** Thank you very much, Dr. Bach and Dr. Chris.

#### ASSOCIATION OF MUNICIPALITIES OF ONTARIO

**The Vice-Chair:** The next presentation is the Association of Municipalities of Ontario. Mr. President, welcome.

**Mr. Doug Reycraft:** Thanks, Mr. Chairman. It's good to see you again. My name is Doug Reycraft. I'm mayor of the municipality of Southwest Middlesex, a county councillor in Middlesex and president of the Association of Municipalities of Ontario. With me this morning is Petra Wolfbeiss, who is a policy adviser with the ministry.

I want to begin by saying how much AMO appreciates the fact that these hearings were delayed until after the Christmas break. I know that at one time it was contemplated that they'd be dealt with before Christmas, and between the new Municipal Act and some other things, we had our hands more than full at that time. We appreciate the fact that we've had time to prepare for the hearings on this bill.

I want to make a few observations that AMO believes are very important.

First, I believe we all recognize that the quality of life, safety and well-being of residents in Ontario's long-term-care facilities is a top priority for the province, for our communities and for the people of Ontario.

Second, I know we agree that individuals, private and not-for-profit agencies, and governments providing services to vulnerable populations must be truly accountable for the quality of care they provide.

Third, I think it is widely recognized that municipally operated homes for the aged do an excellent job, under the current legislative framework, of providing the highest quality services that routinely exceed provincial standards.

Fourth, and perhaps less widely recognized, Ontario's municipal governments go far beyond what they are required to do in law by investing a net \$270 million a year of municipal resources in the provincial long-term-care system through the funding and operation of homes for the aged. They do so because they recognize the need for services in their communities and because provincial funding for the provincial long-term-care system is woefully inadequate. In Middlesex county, the municipal subsidy to this provincial program will be over \$825,000 in 2007 for 160 beds in a brand new facility in Strathroy. That's over \$5,000 per bed per year, and that's much lower than, perhaps less than a third of, the average experienced by counties and regions across this province.

My final observation is that, given what I have just said, it is surely not the intent of this bill to encourage municipal governments to vacate the industry to the greatest extent possible, yet that is the concern that is being expressed among municipal governments today.

While we believe the government's intentions are laudable, our assessment of the bill itself is that it is excessively heavy-handed when it comes to regulating the operation of homes for the aged, with many of the measures having nothing whatsoever to do with the quality of life, safety or well-being of our residents.

In the case of municipally operated homes for the aged, to put it quite simply, this bill sets out to fix something that is not broken. The result is a level of liability exposure for municipal councillors and property tax-

payers that is unprecedented in Ontario's legislative history. As the bill reads currently, municipalities would be well advised to reduce services and investment in Ontario's long-term-care system and provide only the minimum mandated level of service to their communities.

And there is another result. By compounding the current administrative responsibilities of those operating homes for the aged without increasing provincial funding in the system, the bill will require administrators to reallocate resources away from patient care to administration, with a consequence of reduced services. Surely it is not anyone's intention to reduce the number of beds in our communities by taking a heavy-handed approach to addressing a problem that does not seem to exist in the municipal operation of provincial long-term-care services.

Before I address a number of specific concerns, I would like to provide the committee with some contextual information.

Municipal governments operate over 16,500 beds in long-term-care homes in Ontario. That is nearly a quarter of the total beds in this province. In any given year, that is over six million days of care. As I mentioned earlier, municipalities also invest a net \$270 million of property tax revenues per year into the operation and capital development of their long-term-care homes. That averages over \$16,000 per bed per year.

As the most accountable of the three orders of government, municipalities operate under significant scrutiny. As a mayor and municipal councillor, I can tell you that poor service or poor standards in a municipal facility would not escape this scrutiny.

As the minister has acknowledged, municipalities are not only leaders in long-term care but committed to the provision of quality long-term-care services. Yet, over the years, municipalities have seen the increased cost of new standards without corresponding provincial funding support.

And finally, by way of context, the government's commitment to increase operating funding to \$6,000 per resident per year, as expressed in its 2003 election campaign, has not been achieved.

The bill places great emphasis on the enforcement of standards. AMO agrees that administrators of homes for the aged must be accountable. But the bill will require administrators to spend a great deal more of their time and resources on compliance and documentation, and unless the government provides additional funding, homes will be forced to apply even more of their limited resources to meeting all the new administrative requirements.

Without provision for additional funding from the province, the act will lead to existing staff resources being reallocated to administrative and other non-resident care activity. That means less money will be getting to the care of residents.

**1120**

Bill 140 would create unprecedented liability for municipal councillors, municipal governments and their

property taxpayers through its heavy-handed approach to the issue of duty of care.

Section 67 is a remarkably blunt instrument. It would set out a requirement that a committee of management or board of management for a municipal home for the aged will "take all reasonable care to ensure" that the operation of the home for the aged "complies with"—and emphasized—"all requirements under this act." Every person who fails to do so would be "guilty of an offence." That means, without any exaggeration, that if a municipal councillor or a member of a board of management cannot demonstrate "reasonable care" to ensure that the administration of the home meets even the most minuscule administrative requirement of a regulation that we've not yet seen, the councillor or board member is guilty of an offence.

This section is not about offences related to the specific wrongdoing, such as failing to report an incident of abuse; those serious matters are dealt with directly in the bill. In fact, this section is not about safeguarding the rights or interests of long-term-care residents. This section is a catch-all of liability that would make anyone think twice about operating a home for the aged or running for a seat on municipal council.

The penalty set out in the bill includes a fine of up to \$25,000 or imprisonment of up to 12 months for a first offence. Furthermore, this section will likely be a significant barrier to recruiting and retaining directors. Interestingly, the penalties far exceed similar accountability sanctions for members of hospital boards under the Public Hospitals Act, imposing harsher offence provisions on the board members of homes than on those serving on hospital boards. If this is the road the province is choosing to travel, it would seem reasonable to align the offence provision under Bill 140 with the Public Hospitals Act.

I want to turn for a moment to issues of standards and licensing. AMO appreciates the need for the ongoing upgrading of homes, but the fact of the matter is that there is no evidence that there is any problem with the maintenance or upkeep of facilities in the municipally operated homes sector. This begs the question of why Bill 140, in sections 150, 151 and 156, would provide ministry officials with the authority to order municipalities to undertake upgrading and other work as a condition of licensing. This authority could be used by the ministry to require municipal governments to make any number of unbudgeted and perhaps unnecessary expenditures without recourse. If this committee agrees that municipal governments are accountable and responsible, then surely giving such sweeping authority to the ministry is unnecessary.

These provisions that I've raised act as disincentives to the expansion of long-term-care services and fail to recognize that it is municipalities and municipal revenues, not provincial standards, that are what is holding the provincial long-term-care system together and filling a quarter-of-a-billion-dollar gap in provincial health care funding.



The future is quite clear regarding long-term care in Ontario. For the municipal role in the province's long-term-care system, Bill 140 appears to be moving the sector towards fewer beds, reduced funding for care, greater risk and greater costs. AMO and many others in the sector foresee an overall erosion of quality, resident-focused long-term care in the province.

What is clearly missing in Bill 140 is a statement that commits the province to preserving and promoting long-term care through adequate and sustainable funding. The government must consider that any new or enhanced standards must be accompanied by appropriate operating funding and must consider the added financial burden that will be placed on homes for the aged and municipalities as a result of the new requirements. The government must, at a minimum, increase operating funding by that amount.

AMO's position on which order of government should be funding provincial health care services is, I think, well known. Until we have achieved our goal of good public policy and good fiscal policy in Ontario, please do not undermine our ability to deliver provincial services effectively. Implementation of Bill 140 without appropriate and sustained provincial funding bodes poorly for the future of long-term care in Ontario.

Finally, let us not undo the good and productive work between AMO, municipalities and the province as a result of legislation that, on the face of it, is designed to fix a problem that doesn't exist, legislation that fails to recognize the municipal contribution to the long-term-care system in Ontario.

We look forward to building on our successes to ensure that long-term-care legislation meets the needs of our vulnerable residents in a sustainable and realistic manner. We urge the committee to consider the important matters that we have raised today.

**The Vice-Chair:** Thank you, Mr. President. We have three minutes left. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for being here this morning and for the presentation. I must say that the presentation is pretty blunt in its concern with respect to the municipal sector's view of where the government might be heading in terms of actually losing spaces. So let me ask you, what would be the three things—I'm not trying to provide a trick here—the top three things that the government could and should be doing with respect to the legislation which would remove both that perception among municipalities and also that potential among municipalities?

**Mr. Reycraft:** Certainly recognizing in the bill the contribution that municipalities and their taxpayers make to long-term care in the province would be important. But the additional administrative requirements, if they can't be reduced, need to be recognized in the form of funding to municipalities so we don't have to further burden their property taxpayers paying for health care service, which we believe should be properly funded through income and sales tax revenues that the province has available to it.

Secondly, we believe that the penalties that are described in the bill are draconian and need to be more realistic and, we've suggested in our presentation, consistent with those that apply to board members of public hospitals.

**The Vice-Chair:** Thank you. Parliamentary assistant.

**Ms. Smith:** We have heard your concerns on that point. I would note that in the previous legislation, municipalities managed their homes under approvals, and it was AMO's point of view or the municipal homes' perspective that they wanted to continue under that regime, and we have in fact continued under that regime. That does not give us any kind of renewal period or period of time when a home's licence would expire and we would have an opportunity to discuss with them what needed to be done with the home. That's why, in fact, we've introduced the concept of orders around needing to do upgrading in the homes. What other suggestion could you make that would allow us the flexibility to have that discussion around upgrades where you're not looking at a licence term or any kind of fixed period of time?

**Mr. Reycraft:** It's my understanding from the legislation that there is no recourse to appeal for any of those orders that might be extended, and I think including that in the bill might be something that would be helpful to municipalities where they disagree with orders that are made on them by provincial inspectors. I understand the problem in the past with respect to the agreements that have been entered into between the ministry and the municipalities. Our experience in Middlesex is usually that we sign those agreements about six months after the year in which they apply. But I would go back to my basic point, which is that there isn't evidence of neglect or wrong-doing or inadequacy within the municipal long-term-care sector. I think municipal governments across the province do a superb job in delivering those services.

**The Vice-Chair:** Thank you. Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Mr. Reycraft. That's an excellent presentation. I know in my own community of Waterloo our municipality does an excellent job of looking after the needs of citizens who live in the home that they manage. I find it interesting—you say here that the bill, the legislation "is designed to fix a problem that does not exist." You refer to the bill as being heavy-handed. One of the things you've stressed is that if some of this is to be implemented, obviously there's a need for adequate and sustainable funding. Does the government need to look at dealing with the not-for-profit municipal homes differently than the other homes? Are you suggesting this in some respects? You're saying that the stock could shrink; people aren't going to want to move forward.

**Mr. Reycraft:** The additional administrative responsibilities that are going to be required as a result of the bill are going to have the consequence of either increasing costs or reducing care that's available to residents or—what we would hope for—increased provincial funding to cover the additional costs that municipalities are going to incur. The numbers I provided underlying

financial support for homes for the aged I think suggest that municipal homes for the aged are a different category of health care than the private homes and I don't believe should be subjected to the same kind of legislation and regulation.

**Mrs. Witmer:** Okay, that's what I thought I heard you suggest.

**The Vice-Chair:** Thank you very much for your presentation.

1130

SENIORS' HEALTH CENTRE,  
NORTH YORK GENERAL HOSPITAL

**The Vice-Chair:** The next presentation will be by the Seniors' Health Centre, North York General Hospital. You can start whenever you're ready.

**Ms. Helen Ferley:** Good morning, everybody. My name is Helen Ferley and I thank you for the opportunity to meet with you today. I'm administrator at Seniors' Health Centre, which is a 192-bed long-term-care home run by North York General Hospital. One board operates the total hospital, and we do have charitable status. I am an RN by profession and I'm also a surveyor with the Canadian Council on Health Services. Due to my clinical experience, I survey across Canada and I survey both, on the acute side, the rehab complex continuing care and long-term care.

I do want to recognize the work that's been done so far to Bill 140, but in the absence of time, I'm not going to comment on the strengths of the bill; I'm going to keep my comments to areas that may need—

**Mr. Bill Mauro (Thunder Bay—Atikokan):** Motion for extra time.

**Ms. Ferley:** The first area I would like to comment on is resident/patient flow. We all know that flow is not related to one area of the health care system and that it has a domino effect. If something happens, it can slow down the whole system. The implications of Bill 140 around admission to a secure unit may well have implications on patient/resident flow across the system. There probably will be a time delay, there probably will be an increase in ALC bed times on the acute side and there may well be an increase in the vacancy rates in the secure unit while the paperwork is being done.

Interestingly enough to note, in Bill 140 there are a lot of details around admission to a secure unit, but there's no reference to what happens if the POA refuses the admission on behalf of the incompetent person.

Very quickly, I'd just like to talk about the assessments of applications. Notice that Bill 140 does now require assessments to be current within three months. It also requires a written notice that a reassessment has been reviewed; behavioural history for the last year has to be included, and the mental health history requirements have to be included as well. I just have a concern with how, realistically, all this can be given, given the system at the moment. If this does stay in, obviously there will be an impact on time and workload.

Very briefly, I'll talk about licensing—you've heard a lot about it this morning. But from a charitable organization, licensing may have some impact on the ability of the facility to fundraise, because many donors will give an endowment, where the money comes in on a regular basis over an extended length of time. If there is inconsistency and uncertainty, it may impact on the ability of the charitable organizations to fundraise.

I'd now like to spend some time talking about quality outcomes. I think there is a real commitment by many of us who really enjoy working in long-term care to the safety of our residents and the quality care we can provide. When I read the Bill of Rights, number 12—that restorative care is there “to promote and maximize independence to the greatest extent possible”—my comment, based on what was said earlier this morning, is that that “restorative care” is broader than “rehabilitation.” Restorative care is a concept in long-term care, not a particular program. It's a concept that's intertwined, interlaced across all the disciplines and across all the programs.

I'll just tell you very briefly a short history of a research study that was done on restorative care. A nurse practitioner did research on a small number of residents, asking them what meant a good day to them and what meant a poor day to them. The findings of that small survey were absolutely startling to us. What they said was that they wanted the freedom of choice so that they could use their limited energy to do what was of interest to them. One resident, for example, did not want to be kept with the one person and transferred on and off the toilet; she wanted to be mechanically lifted. The reason for that was she wanted her energy so that she could lift the phone and speak to her daughter. Another resident who was very complex did not want to wash herself in the morning, and the reason was she needed her energy, which was limited, to read her book for extended periods during the day. So given the fact that we probably lose 20% to 40% of our residents in a year, restorative care differs in very many levels across the whole concept of care.

If we're looking at restorative, long-term care is now looking at chronic disease management, with health promotion within chronic disease management, rather than actually going through rehabilitation-restorative.

Just briefly on the quality reviews, it's in Bill 140 that inspectors now will have access to all information. All long-term-care facilities, mine included, really want to develop a culture of openness and transparency, where near misses, mistakes and that are openly discussed and brought forward. We need to be able to support our values. My values are listening, learning, leading and serving. I have to have the ability to support those values through an open culture, so I'm suggesting that long-term care be allowed to continue under the Quality of Care Information Protection Act.

I support satisfaction questionnaires 100%, but if they continue to be done in a decentralized fashion as they are at the moment, with each home doing their own, I think we lose the strength of the results of the satisfaction



questionnaire. So I strongly promote that a satisfaction questionnaire is done province-wide through a centralized approach.

**Funding:** You've heard a lot about it, and I'm just about to say that this legislation must be backed with adequate funding and resources.

On governance, I was pleased to hear the presentation before talk about the responsibilities and liabilities for board members, and just encourage this committee and government to look at having consistency across the acts, such as the Public Health Act and the Nursing Homes Act.

I'd like to spend a few moments talking about rights and responsibilities. As I read through the act a couple of times, I noticed quite markedly that there was variance, and not a balance between rights and responsibilities. I think the rights and responsibilities have to not only support our residents, they have to also support the professional staff in the home so that they can definitely use the full scope of their professional abilities. Also, they have to support what the crown expects.

For example, residents have extensive rights. They can enforce a bill of rights against the licensee in subsection 3(3). The licensee has extensive responsibilities. For example, they do not have the right to relocate a resident even if he or she acts maliciously; subsection 24(3). The inspectors, as has already been mentioned, have extensive rights. They can give an order to do or refrain from doing anything, and they can also direct the licensee to perform any work or activity that is necessary in the opinion of the person making the order. So our concern is around responsibilities and rights, that there has to be a balance, and the subjectivity around some of the way this is written should be reduced.

From a closing comment point of view, I do recognize the work that has been done. We recognize that there are very strong points in this act. I think all of us who work in long-term care and really enjoy it really want a strong process there so that we can give good care and so that we can feel proud of working in the environment we do. But when I look at the act as it is written at the moment, a lot of policy is moved into legislation. It's quite descriptive, and it's quite directive. My question is, how can descriptive, directive legislation be adaptive in the future, when in this world changes come very quickly and changes probably will continue to come within the health care system?

When I ask myself what one measure would be necessary to make this act truly realistic out there, so that the act could be a cornerstone for long-term care, so the act would respect the residents' rights, would make a difference and would build community confidence, I am in total agreement with everything that has been said before me by the other presentations. There will need to be a lot of funding and resources put in to support what this act is expecting.

Thank you. I know I've rushed through that.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We can divide

them equally among the three parties. We'll start with the parliamentary assistant.

**Ms. Smith:** You commented on the consistency of governance when you were talking about the governance issue. Can you just expand on what you meant by "consistency of governance"?

**Ms. Ferley:** The governance when it was relating to liability and responsibility for the board members? The Public Health Act has a different expectation than Bill 140 has. Because an organization such as our own has one board for both the long-term care and for the hospital, and there are other organizations which are in a very similar position to ours, I would suggest there was a consistency there between the two.

**Ms. Smith:** Okay. I missed a little bit of your presentation on restorative care, but you were talking about the choice and the need for choice for the residents. I'd just point you to the plan-of-care provisions in the legislation, where we've actually mandated that there be resident involvement—as well as their substitute decision-maker or their family member—in the development of the plan of care and that it also be collaborative between all of the professionals and front-line workers who are involved in the actual activation of the plan of care, so to speak. Is that the kind of thing that you would support?

1140

**Ms. Ferley:** I would definitely support it. It's just the wording of that bill of rights, number 12, that restorative care is "to promote and maximize independence to the greatest extent possible." When I use it on a personal basis, if I went to a trainer today and they said, "I'm going to maximize your potential, and you're going to be back and run 20K"—I don't want to run 20K. So I'm just concerned about the wording here, that it's to "maximize independence to the greatest extent possible." I think it needs to be qualified based on the resident's wishes or something.

**Ms. Smith:** The bill of rights is actually there to ensure or entrench the rights of the resident, so it would be up to the resident to use that to enforce it. So if they feel that their restorative needs are being maximized, in whatever way that is, then that's meeting that—

**Ms. Ferley:** Also, restorative care is a concept rather than a program.

**Mrs. Witmer:** Thank you very much for your presentation. I appreciate the experience that you bring to the table.

You talked about the need for the bill to be more flexible; maybe you could expand on that. You also talked about the need for better balance between the rights and responsibilities for residents, staff and inspectors. Can you expand on that? What is your perception of the role of the inspectors in this legislation?

**Ms. Ferley:** When I read about the role of the inspectors in this legislation, it appears to be an inspector type of role rather than a supportive one. I think the health system, in a broader context, has moved to safety of people and to supporting and more open encourage-

ment. To me, the conflict is that within the home, we're trying to have an open, home-like environment, where there is openness, where there is encouragement to bring forward near misses, where there is encouragement to discuss issues, and then on top of that, outside it, we've got this more directive, prescriptive approach. There is a conflict between the two. Go into different organizations; you don't hear legislation mentioned in complex continuing care when you're out there. You don't hear legislation mentioned that much on the acute side. But if you walk into a long-term-care home, within the first hour there will be some comment around the strictness of legislation. That is where I would like to see balance: where there is the ability for the home to still have the broad guidelines, that they do a really good job in line with residents' rights and in line with residents' wishes, but at the same time have a more supportive environment to do it in rather than a punitive one.

**Ms. Martel:** Thank you for your presentation here this morning. I want to focus on the funding, because you said several times—and in fact at the end you summed it up by saying what measure would make this realistic, and that is that there be the funding in place to back up what the government is requiring. In your own organization, have you tried to sort that out or cost that?

**Ms. Ferley:** Because we're not-for-profit, my nursing envelope is always over budget by a couple of hundred thousand dollars a year, which is supported through the accommodation envelope. Even with that support, the RN hours in my organization are 14 minutes per resident per day, and an RPN is 21 minutes per resident per day. Their job includes all of the non-professional duties within that time frame. From professional staff, the amount of time per resident per day is absolutely minimum. My health care aides are working one to 10 on days, one to 13 on evenings, and one to 20 on nights, for complex continuing care, where we're getting many people from the complex side who are not now meeting the MDS requirements in the complex organizations, who are now coming in to long-term care. The care at the bedside level is not adequate to support either the professional side or the non-professional staff.

**Ms. Martel:** So if you have to take money from somewhere to deal with administration, you're already supplementing that personal care envelope.

**Ms. Ferley:** We're supplementing the personal care envelope. Last year it was over \$300,000, and this year I'm still in the same bracket. That all comes from—as a not-for-profit, I can put that into it. I don't buy any equipment from that either. It is pure salaries and supplies for care.

**The Vice-Chair:** Thank you very much for your presentation.

#### NATIONAL PENSIONERS AND SENIOR CITIZENS FEDERATION

**The Vice-Chair:** The last presentation is the National Pensioners and Senior Citizens Federation. Sir, you can start whenever you're ready.

**Mr. Art Field:** Thank you for letting us come here. I want to explain that I had a handout for you that was prepared by a friend of mine.

Our organization is a national organization. It's a voluntary group. It comes from across Canada. In the bio that I gave you, or the brief, as it's called, is a list of our executive. The secretary is in Saskatchewan. There are two people in Newfoundland, and the second vice is in Nova Scotia. The treasurer and myself, the president, are from Ontario.

When I go to conventions, I seem to draw the time to speak at 11:45. When you're at a seniors' convention, you don't want to go over your 15 minutes because they're ready for lunch, and I'm sure you guys are too, so I'm not going to be long.

I'll just give a bit of background. I live in Little Britain, Ontario, which is near Lindsay. Now it's called the city of Kawartha Lakes. It has a high density of seniors; some are very affluent and some are not. There are quite a few nursing homes there. This is why I am interested. But I'm also interested because, at our convention that we have every year, we have a lot of resolutions on health care, on nursing homes, and they're from all across Canada, obviously. There seem to be lots of problems. The problems are the same; it's just that they're in different parts of the country. So we're just trying to help the committee here to establish better care.

It's amazing that Ontario doesn't have any time limit for care but Alberta, Saskatchewan, Nova Scotia and all of those have some time. I hope that you can put it in. Hearing the two people before me, I guess it's money. We now have more people in nursing homes than we've ever had before, so obviously we need more money. They need to be looked after better because of the situation.

My father was in Victoria Manor, which was in Lindsay. The care was good, it was acceptable, but I saw days there when I would go in to visit—in the end I was in feeding him—and the floor would be extra dirty or not cleaned because of the shortage of staff. That's also part of care, of looking after—the place has to be clean. I realize that if there's a shortage of staff, they have to prioritize what they do. That's what I think the bill has to do to look after things. As I said, our organization is from across Canada.

The other thing: I see in the paper the food costs. If you live in a jail, you get more money for food than you do if you live in a nursing home. There's something wrong here and I hope the committee can change that.

Other than that, you have my short brief. I'll answer any questions if I can and we'll let you go to lunch early.

**The Vice-Chair:** Thank you very much for your presentation. We have a lot of time for questions. We'll start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for coming forward, Art, to make this presentation. You've indicated here that, regrettably, this bill is going to create a huge amount of paperwork for the staff and, at the same time, it's not going to do that much to increase the level of care



or of programming for the residents. What suggestions would you have for the government to make changes? What would you suggest they do to kind of tilt the balance the other way?

1150

**Mr. Field:** In this society now, we seem to have less workers, less people and more technology. It seems to make it longer and harder to go through it or get done. If the government is demanding, as the lady before me said, more administration work, then obviously they should have more money there and hire more people. As a society, if we are all not working, then nothing is going to work. I guess I didn't tell you my background. I was an auto worker in Oshawa for 35 years, involved there in the political process, involved with the union. All they're doing nowadays is cut, cut, cut, cut. They're doing it, and some of our administration buildings are doing it, and the government. We've got to stop somewhere.

On my side are my grandchildren and your grandchildren, and for some of you people it's your own children. If there are no jobs for them, we're not going to survive, never mind being able to supply support to our seniors who need it.

**Mrs. Witmer:** Thank you very much for coming forward.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you for driving here today to make the presentation.

**Mr. Field:** Today's better than yesterday.

**Ms. Martel:** You've got that right, Art.

You mentioned at the start that Ontario doesn't have any rules or standards in place with respect to how many hours of care would be provided to a resident and that other jurisdictions do. Of course, the Liberals promised to do that in the last election, and now they're not living up to that promise. From your perspective, why is it important that there be some rule, some standard, around even the minimum level of care that a resident should be expected to receive?

**Mr. Field:** It's like everything else, I guess. It's a shame that you have to put these rules there, but if they are not there and there aren't criteria for the management or the worker to follow and you're short-staffed, especially in the private ones, then—because the bottom line is profit. So if they can get away with it, they will. Obviously, that's why there are rules. Other provinces have put in rules so that they have to supply a certain amount of staff care per day, which is sad, but we have to look after—if we're supplying, as a government or as a taxpayer, places for people to live, they've got to live in dignity, regardless of their financial background or whatever.

**Ms. Martel:** And of course "minimum standard" means just that, only a minimum standard to ensure some level of care. For those people who need more, you would expect, of course, that they would get more and that by having a minimum standard, you're not taking away from those people who might clearly need more care as well.

**Mr. Field:** No, I would hope not. But it's sad that we have to put in a minimum standard because the system is not allowing the worker, the caregiver, to perform her or his duties to the standard that they want.

**Ms. Martel:** Because there's not enough staff?

**Mr. Field:** Because there's not enough staff.

**The Vice-Chair:** The parliamentary assistant?

**Ms. Smith:** Just a follow-up on your discussion about minimum standards: Don't we run the risk, if we have a minimum standard, that we'll have people working just to that minimum, and those who actually need more care may not be getting that level of care?

**Mr. Field:** I suppose you could call it management's prerogative to make sure that the caregiver or worker does the job that has to be done. So some people maybe only need minimum and some need more. I guess if you're making it a law, then it means that it should be done and there's a background for somebody—the family—to make sure of getting their parents looked after properly.

**Ms. Smith:** Right. In the province over the last three years, the government has made some substantial investments into long-term care. I know you mentioned that there are a number of homes in and around your area. We've actually hired about 4,900 new front-line workers, including about 1,100 nursing staff. In your visits to the homes in your area, have you seen any improvement in those areas?

**Mr. Field:** To be truthful, my father passed away in the home he was in, and it's sad to say that I haven't been into the homes since then. I'm just going on the bit of information on friends who have gone—I have friends who work in the homes also, but I'm not going around and being Art the cop to see what's going on, because I don't have the time. I wouldn't mind doing that, but I don't have the time because of the other things that I have to do.

**Ms. Smith:** Absolutely. I appreciate that.

I wanted to talk for a minute about your comparison on the food costs and just put to rest that myth that keeps getting out there about the level of expenditures in prisons versus long-term care. The numbers that have been put out there were actually apples and oranges. Just for your information, in prisons the \$11.43 per day per inmate is actually the cost that includes raw food and preparation and service; a comparable number in long-term care, using comparable inputs, is about \$18.10, so in fact we spend more on our long-term-care residents than we do on our inmates, just to be clear.

I want to thank you for coming in today, and actually I want to thank you for explaining where Little Britain is, because I saw that on the agenda and I wondered where it was. So thank you so much for your interest.

**Mr. Field:** Just to comment on the food cost, I agree with you, but something like that gets out and the first thing the senior sees, or your neighbours who aren't seniors—it's, "Look at this. The government is doing" whatever. It's a hidden thing, but that's part of what goes on. It's called image, I guess, or press releases or

promoting what we do. That was promoted for some reason, and then obviously you know how that goes.

**Ms. Smith:** Absolutely. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. Now we will recess until 1 o'clock sharp.

*The committee recessed from 1156 to 1306.*

#### ONTARIO COUNCIL OF HOSPITAL UNIONS

**The Vice-Chair:** Good afternoon, ladies and gentlemen. We'll start with the afternoon session. We have with us many of the presenters; first, the Ontario Council of Hospital Unions. You know the procedure. You have 15 minutes. You can use them all or you can leave some for questions. You can start whenever you are ready.

**Ms. Candace Rennick:** Hello. My name is Candace Rennick and I am the president of CUPE Local 2280, representing workers at a not-for-profit charitable home for the aged in Peterborough. I have the pleasure to present today on behalf of the Ontario Council of Hospital Unions, who rightfully are very concerned about the downloading of acute and mental health patients from hospitals into long-term-care facilities.

I have worked at the home in Peterborough for 12 years in different capacities, but mainly in ancillary services. I wanted to start by thanking you for the opportunity to present to you today, but I must acknowledge the dozens of citizens and organizations who actually won't be getting this opportunity. I would be remiss if I did not express my extreme disappointment with the limited amount of public hearings. This appears to be an attempt to fast-track a bill that deserves broader and wider public consultations. I would think that you should all be concerned about hearing from as many people as possible on this proposed legislation.

I know of several people personally who were denied. Further requests from several residents of Peterborough to bring a hearing to that community have been unanswered. Peterborough has one of the most aging populations in the entire province. We have more homes there than Tim Hortons by far, and the vast majority of them are privately owned and operated for profit.

I'd just like to put a couple of questions to you. I'd like to ask you, could you imagine sitting in your feces or urine for hours on end because there is not enough staff to assist you immediately, or could you imagine being rushed through your care and being up, cleaned, dressed and ready for the day within 10 minutes from the time you open your eyes? Could you imagine sitting up for hours on end, waiting to lie down for a nap, but having no staff available to assist you? Could you imagine health care workers endangering themselves and you by using a two-person lift alone, just to be able to provide you some comfort, because there is no staff to help? Imagine sitting alone day after day, no visitors, no family; friends are gone. A chat about the weather or current events has become a long-lost luxury. Can you imagine that after long, hard work, you live your last years in such inadequate conditions in one of the richest provinces and

one of the wealthiest, most privileged countries in the entire world, thanks to many of the people who call long-term-care facilities in Ontario their home? Can you really imagine that?

Well, folks, I see those conditions each and every day. They are not exaggerated; they are reality. That is why minimum staffing standards required by law are so important. They will guarantee additional resources for front-line care and enhance the quality of living and working conditions for residents and workers in long-term-care facilities.

Long-term-care workers do the very best they can with the resources that they have, but it is not enough. And all too often, caregivers are leaving their shifts feeling guilty that they didn't have the resources to do more.

Injury rates continue to be among the highest of any industry, and burnout, stress and low morale have bottomed out for the past several years.

Violence continues to be on the rise in facilities as a great many mental health patients and mentally challenged and disabled individuals are downloaded onto an already strained system. Caregivers are often not trained to deal with these types of special behaviours, and there is no stimulation in long-term-care facilities for these types of residents.

I have personally witnessed many young people with disabilities in these long-term-care facilities go downhill at a rapid rate. People who walked in and spoke to you when they came in now don't speak and spend all of their time in geriatric chairs. People with mental difficulties and disabilities should not be downloaded onto the long-term-care system. They should be placed in institutions or homes that will truly meet their needs.

In facility after facility, providers are making decisions to not replace workers who are off sick and who are on vacation. All of the examples that I just cited at the beginning are examples of a fully staffed facility, so just imagine being told that four of your co-workers aren't coming to work today and that you have to pick up the slack of their 40 residents. Obviously, residents become widgets.

Who holds providers to account for decisions like this? They develop staffing models to meet the needs of residents in good faith, often not adequate in the first place, and then they make decisions strictly based on financial reasons to not work with a full complement of staff. Conditions on those days for workers and residents are not just inadequate, they are horrible. We call the compliance hotline. We're told that compliance can't talk to our providers about how they spend their money. So who does?

As I mentioned, I come from a not-for-profit organization in Peterborough. My employer is not seeking to siphon profit from the accommodation envelope; instead, they transfer up to \$100,000 a year into the nursing and personal care envelope to make up for the obvious shortfalls. I would offer that the conditions, even with this top-up, are not adequate—and like I said, in a charitable, not-for-profit home. So it does beg the question, what is happening in the for-profit-operated homes? Their goal is



to earn profit. This is a booming industry in Ontario, and why is it booming? Because there is money to be made, and there is no protection from the government, and no plans to limit the expansion of the for-profit sector.

Minimum staffing standards would mean that service providers would not be able to make decisions that are harmful to staff and residents based on funding problems. They would be required and held accountable to provide the 3.5 hours of care per resident per day. It would be a guarantee to seniors about the care that they can expect to enjoy.

How do the minimum staffing standards work? A facility with the average case mix would receive resources for 3.5 hours. Facilities with lower acuity levels would receive less, and those with higher acuity levels would receive more, just like when the standards did exist under the 2.25 hours.

This may be the only piece of long-term-care legislation we see for several years. It needs to protect in a real and meaningful way the seniors of this province. CUPE, the Ontario Council of Hospital Unions and our allies will not accept a bill that does not include minimum staffing standards.

I am pleased to see the whistle-blowing protection in the legislation. A worker in my facility spoke out about the conditions in our home, and she was suspended for five days without pay. Five days without pay: That's close to \$600.

I have to offer that I think the whistle-blowing protection is a bit weak. I don't think it fully protects whistle-blowers when they blow the whistle on conditions they've witnessed. You still have to go before a labour board or an arbitration board, and ultimately, at the end of that process, you do still risk losing your job. So I'm not sure how that is protection; I fail to see that. But I am happy that it's there and that we're moving in that direction.

Surprise inspections: I applaud the government for implementing surprise inspections of long-term-care facilities, but compliance officers must also be obligated to speak with and record staff comments and concerns. They need to ensure that staff feel comfortable and that that's an environment where they can come forward and talk about those things.

I also understand that some compliance officers allow facilities to produce what charts will be inspected. Like the visits to the home, viewing of documentation should also be random and selected by the compliance officer.

I by no means claim to be an expert on the legislation. I would refer you to the CUPE Ontario brief for the things that I've not touched on in my conversation today, but I do want to thank you for the opportunity. I would encourage you during your clause-by-clause review to pay serious attention to creating minimum staffing standards, because it will be real protection and accountability for residents living in long-term-care facilities. The Liberal government, as many of you around this table will know, promised to reinstate those standards in the last provincial election, and on the eve of another provincial election, it cannot be another broken promise.

If you have any questions, I'll do my best to answer them.

**The Acting Chair (Mr. Bob Delaney):** Thank you very much. We should have enough time for one brief question from each caucus, beginning with Ms. Martel.

**Ms. Martel:** In your view, why is it so important to have a minimum staffing standard? It would probably have to be higher than the 2.25 that was in place, because that was over 10 years ago.

**Ms. Rennick:** I think that the residents deserve a level of protection. They need to know that there's going to be a guarantee of staffing standards, that they're going to receive a level of care. I think that it's also going to hold service providers to account for their constant non-replacing of workers, allowing facilities to work short. They would have to meet that threshold. I think that the standard should be implemented.

**The Acting Chair:** Ms. Smith?

**Ms. Smith:** Two quick ones: Are you the same Candace Rennick who was on CBC saying that you weren't appearing before the committee this morning?

**Ms. Rennick:** Yes. I said that I was actually denied the opportunity to present on behalf of what—I had applied and was denied, and I was lucky enough to be offered the Ontario Council of Hospital Unions' presentation spot this morning.

**Ms. Smith:** Your view on whistle-blowing protection: You think that it doesn't fully protect workers. What is it about the whistle-blowing protection that you don't think is adequate?

**Ms. Rennick:** I guess I just don't understand why, if there is protection for workers, they would still have to fight it out at an arbitration board and risk losing their job at the end of that. I don't even really understand why the arbitration hearing would have to come into the process. If there was real protection for workers, it would be real protection for workers, and they ultimately wouldn't have to fight for their jobs at the labour board or an arbitration hearing.

**The Acting Chair:** Mr. Arnott?

**Mr. Ted Arnott (Waterloo-Wellington):** Ms. Rennick, thank you very much for your presentation. I'm pleased that you've had the opportunity to express your views and the views of your membership. I think you've done a very passionate and eloquent job of talking about the important care and services that your membership provides for people. I believe in standards too, but I think, perhaps more importantly, that the care of seniors depends on the compassion and dedication of your members, and we express our appreciation for that.

**The Acting Chair:** Thank you very much for having taken the time to come in and make your presentation this afternoon.

JANET HOLTRUST  
DAPHEN STANTON

**The Acting Chair:** Janet Holtrust, please. Good afternoon. Welcome. I see two of you, so please begin by

introducing yourselves for Hansard. You'll have 15 minutes to do your deputation this afternoon, and if you leave any time, it'll be divided among the parties for questions. Please proceed.

**Ms. Janet Holtrust:** Thank you, Mr. Chair and members of this committee, for allowing us to make a presentation to you today. My name is Janet Holtrust. With me is one of my co-workers, Daphen Stainton. We are both personal support workers, with many years of experience between us. We work in a for-profit nursing home owned and operated by Central Care Corp.

We are here today to make a request for a minimum standard of care hours for long-term-care facilities. We were told by Mr. Smitherman that there would be a "revolution in long-term care." He stated that he would fix the problems that were facing troubled nursing homes. It is with great disappointment and regret that we inform you today that in fact there have been no real changes or improvements to the amount of care or the quality of care seniors receive today.

The hours of care in our facility is 2.23 hours per resident per day. This is at an optimal level. We often don't get to 2.23 hours. Yesterday we worked two short, the day before that we worked one short, and the same for the day prior to that. This is just for the day shift. It needs to be made clear that the expectations from the employer are the same regardless of what our staffing levels are. Only yesterday the administrator called all the PSWs together to inform us of our obligation to complete our baths regardless of staffing. "Other homes get it done," she said. "We should be able to too."

On a regular basis we work with a complement of staff less than required and scheduled. This reduces the time we are able to spend with each individual resident. When staffing levels are met, the average PSW is responsible for the care of approximately 11 people. When we work short, each PSW becomes responsible for up to 13 or 14 residents.

1320

The ministry has also imposed a two-baths-per-week mandate. This is great for the residents, but again it's more work with no additional staff. When we work short, the time spent bathing a resident takes away from the care we need to provide for other residents. It also leaves us unavailable to assist our partner with transfers and to monitor high-risk residents.

There are many reasons we work short, including illness, WSIB injuries and stress leave. We also struggle to maintain staff, including administrators and managers. Quite often new employees quit because they are unable to keep up with the workload. It becomes so overwhelming that they leave and never come back. We are unable, much of the time, to recruit new staff due to our rural location. In fact, at this time we are laying off nursing staff. So much overtime has been paid in the nursing department that we in fact exceeded our budget. We now fear more layoffs will come. It's cheaper to pay straight time; it's less stress on the staff, much more cost-effective and ultimately better for the residents. Nursing

staff often work 16-hour shifts, then return again in eight hours to work another full shift. There have been situations where staff have had to work a 24-hour shift. Weekends have been a nightmare for the staff and residents alike. Employees just don't want to work every weekend and should not be expected to do so. Vacation time poses the same ongoing problem. Staff are even called while on vacation to work.

So you see, without a standard of hours that employers are required to meet, things simply are not going to improve. The government provided funding for new equipment and new builds, but until there are more staff provided to operate that equipment and work in the new builds, we are really just wasting taxpayers' money. We have sufficient mechanical lifts in our facility, but we often wait up to 10 minutes to get help in using them.

Truly, this gives a false sense of security to the public. This bill is not going to make lives better for the seniors who currently live in long-term-care facilities in this province. What they really need the most is more staff.

**Ms. Daphen Stainton:** Just throwing numbers out there doesn't give a clear picture of the truly sad situation in nursing homes. For this reason, I would like to share with you a typical day for us and for the residents.

At 6:30 a.m. we start our shift and receive report. Shortly thereafter we do a quick check of our residents to make sure they are safe and accounted for. We then stock up on linen and other nursing supplies. Quite often we are searching in vain, as there are insufficient supplies available.

Now it is almost 7 a.m. We start morning care for our assigned residents. On a day when we are fully staffed, we have approximately 11 people to care for. Each resident should be provided about 15 minutes for care.

At 8:15 we are to stop care and take residents to breakfast. So 15 minutes per resident times 11 residents is 165 minutes. There are only 80 minutes available to meet the needs of these individual patients prior to breakfast.

Please consider also that during this time we have a partner that will require assistance to transfer his or her residents. The buzzers will ring and we must stop what we are doing to answer them immediately for safety reasons. Oftentimes we have to stop everything to address medical emergencies, residents who become aggressive and/or agitated. If this happens, we are likely going to be late for meal service. Not all residents have to come to breakfast dressed for the day. We are allowed to send them in in nightclothes, but they still need time spent with them to prepare them for leaving their room, regardless of if they are dressed or not. So simple math will show that 15 minutes per resident is not possible.

At 8:30 we start serving breakfast. Increasingly, there are more residents to feed and to assist than there is staff. We cannot rely on other departments, as often there is no one to assist. We struggle though a very busy meal and then porter all residents to another area of the home.

It is now about 9:15. We have documentation to complete, breaks to take, bathroom requests from



residents to meet and residents who require being put back to bed.

At 10:30 all staff converge to do the nourishment cart. This takes about 30 minutes, and then we move on. The beds need to be changed, laundry needs to be taken down and documentation needs to be done. During this time, we continue to answer buzzers and assist any residents with other needs.

Usually by now it is 11:30. We start getting the residents up from their nap and porter all residents to the dining room for lunch. This does take up to about 30 minutes to complete. We go through another busy meal and then follow the same routine again. By now there are many more residents who go to bed for a nap and others who again need a trip to the bathroom.

It is now 1:30 p.m. We take our lunch break, complete documentation and do our report for the next shift. We take down more laundry and check our residents again. The shift is now over. It's 2:30 p.m.

**Ms. Holtrust:** This day has been laid out to you with no exceptions. Further to basic care needs, we feel there has been an increase in resident falls in our home. We would not be surprised to find that we are above the provincial average. Many of our residents require constant monitoring to reduce the risk of falling. New alarms have been made available, but again, you can have the equipment, but if there is no staff to respond quickly enough to those alarms, then they are ineffective. We also have to assist residents with all appointments they may have to attend that day.

Twenty years ago, when I started nursing in this facility, we had the same amount of staff for the same amount of residents. At that time, almost all our residents were ambulatory; now almost all are in wheelchairs. Then, most people were continent, and now most are incontinent or require assistance with toileting. Back then, they were able to feed themselves, and now almost half require feeding or some level of assistance with feeding. You could also leave a resident alone in their room to eat a meal; now you must stay with them. The level of care has tripled, but I can say our staffing has not increased to meet the demands. The ministry standards were much different 20 years ago. Now they are quite strict and require three times the amount of documentation. The time spent on charting takes away from hands-on care.

This inability to provide the level of care we should be giving to our elders is emotionally trying and frustrating to health care workers. We are trained to provide holistic care, yet always we are looking for ways to cut corners to keep up with the workload. Their needs far exceed the basic activities of daily living that we struggle to meet each day. These people have the right to not be rushed and treated like a number. They should also have the right to have staff be able to make time for them when they need to cry on our shoulder or if they just need to talk.

A typical day for a senior is much different from ours. They will wait until someone has time to provide them

with their morning care. They will see us for a few minutes only. We will come back to get them for breakfast and spend another minute or so talking to them on the way to breakfast. If they are classified as a total assist or a feeding resident, then a nurse will sit with them during that meal; otherwise, they will be served their meal and left to eat with their tablemates. After breakfast, we will porter them to another area of the home. If they require assistance with any nursing needs, we will provide it at this time. This may take up to 10 minutes, depending on the needs of the resident.

Now they will sit and wait for any activities that may be scheduled. The ministry mandates 1.5 activity aides per 100 residents. It is impossible for all residents to attend an activity program on a daily basis. If there are no programs, they will now sit, likely in front of a TV, sleeping, and wait for us to come and get them for lunch. They wait and they wait and they wait. We will come at some point and get them for their meal and they will go through the same process again. After lunch, they will have their nap and wait for dinner.

You can quickly add up the amount of time residents have had contact with staff. These people are dying of loneliness and boredom. For this reason, they become more dependent on their PSW to be available for all aspects of their needs. These needs, many times, cannot be met.

These people are human beings with the right to be treated as such. We are not factory workers and they are not machines, but this is how both parties feel. These people are the individuals who built this country. They are my parents and grandparents and your parents and grandparents. They are also our war vets that we owe so much to. These people have already endured enough hardship in their lifetime. They have the right to live out their golden years in a safe and comfortable environment. They have the right to dignity and respect. Their needs are few, and yet we continue to fail to meet them. We all know this is not what we want for our seniors, and we all know that what is happening in long-term-care facilities can be changed. It is time that Ontario got with the rest of the world in setting minimum standards of care.

So in conclusion, we plead with you to consider a minimum care hour of 3.5 in Bill 140. It's time to move forward in the direction that will evoke the revolution that Mr. Smitherman promised all of us. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. There is no time left.

1330

#### ONTARIO HOSPITAL ASSOCIATION

**The Vice-Chair (Mr. Khalil Ramal):** Now we'll move on to our next presentation, the Ontario Hospital Association.

**Mrs. Witmer:** On a point of order, Mr. Chair: I just wonder if the committee would consider changing the location for the hearings tomorrow to the Amethyst Room, since that room is available. I think, based on the

public interest we're seeing in the legislation today, it would be an opportunity for people throughout the province of Ontario to learn more about this piece of legislation and be better informed. So I would ask you to consider whether or not that would be possible for tomorrow's hearings.

**The Vice-Chair:** The room is free tomorrow. It's up to the committee to decide if it's going to move to it tomorrow or not. If there are no objections, it's still free. It's up to the committee. Is it okay? Are there any objections?

**Ms. Martel:** I agree with that request, Mr. Chair.

**The Vice-Chair:** No objections? Okay. Then tomorrow would be in room 151. Probably the schedule will remain the same; just our location will be changed. Thank you, Mrs. Witmer.

Now we'll go back to the Ontario Hospital Association. We'll give back your time.

**Ms. Hilary Short:** Good afternoon. My name is Hilary Short and I am president and CEO of the Ontario Hospital Association. Joining me today is Jean Bartkowiak, president and CEO of the SCO Health Service in Ottawa. In addition to serving as president and CEO of a continuing care academic health science centre that operates two long-term-care homes, Mr. Bartkowiak has significant experience in similar roles outside of Ontario.

We are pleased to have this opportunity to comment on Bill 140, the Long-Term Care Homes Act, 2007. The OHA is, of course, supportive of efforts to improve and modernize the legislative framework for long-term care in Ontario.

While a single piece of overarching legislation is an important step towards the ultimate goal, we strongly believe that some changes are needed to improve and strengthen Bill 140 to benefit those who are cared for by and work in Ontario's long-term-care sector.

Bill 140 has important implications for Ontario's hospitals. A number of hospitals in this province own, operate and govern long-term-care homes as well as EldCap long-term-care beds. In addition, long-term-care homes are often a common destination for patients who require post-acute care following discharge from hospital.

While our recommendations are set out in detail in our written submission, I'm going to ask Jean to speak to some of the more important aspects of our submission, and then we'd be pleased to answer questions.

**Mr. Jean Bartkowiak:** Thank you, Hilary. While we have noted a number of suggested amendments in our written submission, I would like to take a few minutes to focus on a number of important areas in which the legislation could be strengthened.

Ontario's long-term-care homes strive to provide safe, high-quality care to their residents. While we are supportive of the intent of Bill 140 to further this objective, we are concerned that a number of the provisions set out in the bill will make it difficult for homes to carry it out.

Many of the provisions currently set out in the regulations to the three existing acts appear in Bill 140. We are concerned that the inclusion of many provisions in the legislation which were previously set out in regulation moves away from a positive culture built on the quality of care and toward a negative culture of enforcement.

We are similarly concerned that the legislation is silent on the value of teaching and research in the long-term-care sector. As fundamental building blocks to innovation and to ensuring the availability of health human resources, we believe that these important values should be clearly articulated in the legislation.

Some specific concerns: We have identified a number of ways in which the bill could be significantly improved, and, with input from our members, have developed some recommendations in this regard. I'll now review some of these recommendations.

**Director and officer liability:** First, I would like to speak to the personal liability that Bill 140 would impose on officers and directors of corporations operating long-term-care homes. Bill 140 would create an onerous standard of personal liability that does not currently exist in long-term-care legislation or other health-related legislation. This has sparked specific concerns among hospitals and not-for-profit long-term-care homes.

We are concerned that the legislation, as currently drafted, would present serious difficulties for not-for-profit boards in recruiting and retaining board members. Ontario hospital boards and boards of not-for-profit long-term-care homes are composed of community volunteers.. In some cases, boards govern both a hospital and a long-term-care facility.

As you know, recruiting and retaining qualified, expert and skilled directors who give of their time without remuneration is critical to the sustainability of the not-for-profit sector. As currently drafted, Bill 140 may become a significant barrier to achieving this. Officer and director liability needs to be consistent across the health care sector and aligned with best governance practices. We believe that amendments to the bill are necessary to ensure that this consistency is achieved.

**Transfer to a secure unit:** Placement of individuals requiring long-term care is an ongoing challenge for hospitals. We support the notion of due process for the transfer of individuals to a secure unit. However, we are concerned that the detailed requirements for transfer set out in the legislation may have significant implications for hospitals that have alternative level of care patients awaiting long-term-care placement.

Bill 140 sets out specific conditions that must be met before an individual can be admitted to a secure unit, such as the requirement to notify a rights adviser in certain instances. Hospitals are concerned that these detailed requirements may further delay the placement process for ALC patients awaiting transfer from a hospital to a long-term-care home. To expedite the process and timeline by which these transfers are made, we suggest that specific timelines, such as the time within



which a rights adviser must provide advice, be set out explicitly in the legislation.

**Regulation-making process:** Another important issue for the OHA and its members with respect to Bill 140 is the need for due process in the making of regulations. As currently drafted, Bill 140 provides the Lieutenant Governor in Council with significant, broad regulation-making powers. These powers can be exercised without having first provided affected residents, providers and their communities the opportunity to be heard on the merits of the proposed regulation.

Public consultation in the regulation-making process is something that is codified in a number of pieces of health care legislation, including the Commitment to the Future of Medicare Act and the Local Health System Integration Act. Given that regulations developed under Bill 140 will have a significant impact on how the detailed provisions of the bill are implemented, we believe that those most affected should have an opportunity to be apprised of and provide input on proposed regulations. We therefore request that Bill 140 be amended to provide for a public consultation process during the development of regulations that is consistent with other health care legislation.

These are a few of the suggestions that we believe will improve and strengthen Bill 140. Further details and additional recommendations are set out in our written submission.

I'll now turn to Hilary for some concluding remarks.

**Ms. Short:** The OHA and Ontario's hospitals support the government's plan to build a stronger and safer long-term-care home system in the province. As I indicated earlier, Bill 140 is a much-needed piece of legislation, so our recommendations are offered in the spirit of ensuring that the goal of creating a resident-centred system that meets the needs and preferences of residents, their families, providers and the system as a whole is achieved. We have really tried to provide constructive advice and recommendations with a view to ensuring that this goal is ultimately successful.

Once again, thank you for the opportunity to appear before you today. We'd be pleased to answer any questions you may have.

**The Vice-Chair:** Thank you very much for your presentation. We have five minutes left. We can divide it equally among the three parties. We'll start with the parliamentary assistant.

**Ms. Smith:** I appreciate your comments. I did have one question on your—I appreciate your concern around the timing of rights advice when transferring into a secure unit. I find it somewhat ironic that you find provisions in the legislation to be too prescriptive, and then, in this case, you're asking that it be set out in the legislation what the timelines are. Maybe you can address that and how you see we could be doing that amendment.

1340

**Mr. Bartkowiak:** You're right, and the reason it's there is because there are other timelines already set out in the legislation. If we're taking up timelines, then they

could be included in the regulations. Our point is that we want the legislators to appreciate that we're facing very critical situations sometimes where the transfer of patients requiring secure environments could be delayed, which will, in turn, impact on admissions of other critical cases in the acute care setting. So both the ER patients and the long-term-care patients are facing issues and problems in that respect.

You have similar situations in psychiatric facilities, for instance, or psychiatric transfers, where the admitting physician signs an order and then there are specific timelines provided for a review of those orders. Maybe this is an area where this legislation could borrow from other existing practices in health care.

**Mrs. Witmer:** Thank you very much for your presentation. You didn't mention this, but you have indicated that you have a concern around the fixed-term licences. Could you explain the concern you have and perhaps the amendment that could be made?

**Mr. Bartkowiak:** My concern has two aspects; one is related to labour relations in that some of our labour contracts could provide for longer terms than the actual licence that would be awarded. What happens, then, with that employer-employee obligation? That has to be addressed. The other impact is mostly for not-for-profit organizations that have loans with banks or other financial institutions where the terms of those loans extend over and above the terms of the licence. The legislation or its regulation should address those specific situations.

**Mrs. Witmer:** Thank you very much.

**Ms. Martel:** Thank you for the presentation today. You noted section 88 of the bill, which says, "The minister may provide funding for a long-term-care home." We heard a similar presentation this morning that suggested that should become "shall" to ensure that there is adequate funding. I don't know if you have a thought on that, one way or the other.

**Mr. Bartkowiak:** "May" is not necessarily as definitive if you put it against all the obligations that are set out in that bill. It seems, from the operators or the licensee, that there should be an equal kind of obligation from the ministry. If we are to comply to provide quality, innovative care to our residents, we have to have some kind of assurance from the payer that he will support and meet financial obligations that flow from providing quality care to our residents.

**Ms. Martel:** My second question is, has the hospital association been able to do or thought about doing a costing of what those additional costs would be from the new requirements in the bill?

**Ms. Short:** We have not done that yet. We could certainly try.

**Ms. Martel:** I'd be interested to see what that turns out to be, because you are not the only group that has expressed a concern about more requirements and the need to have government fund that.

**Ms. Short:** We can certainly do our best to get that for you, for the committee.

**The Vice-Chair:** Thank you very much for your presentation.

The next presentation will be the Ontario Health Coalition.

**Ms. Martel:** On a point of order, Mr. Chair: I'd like to make a request for the clerk to give all of us a list of those organizations and/or individuals who were not able to get standing at the committee hearings and if that can be provided to everybody.

**The Vice-Chair:** To my knowledge, two weeks ago the clerk provided all the members of the subcommittee the information. It's not secret information, is it?

**Ms. Martel:** No. The information that we have is a list of everybody. What I'm asking for is the final list, because I gather there were some duplications in those lists in terms of people putting their names on twice. So if we can just have the final list of who was off, that would be great.

**The Vice-Chair:** Okay. Ms. Martel has put a question to the committee. She wants the information. Are there any comments?

**Ms. Smith:** As long as the list clearly delineates those who chose not to attend even though they were offered a spot, because there were some who deferred.

**Ms. Martel:** If it can show who deferred, and otherwise, if they took somebody else's spot—I don't know if you can do that as well, Trevor.

**The Vice-Chair:** That's okay?

*Interjection.*

**The Vice-Chair:** No problem. Thank you very much.

#### ONTARIO HEALTH COALITION

**The Vice-Chair:** The next presenter: You can start whenever you're ready.

**Ms. Natalie Mehra:** Thank you for allowing us this opportunity to speak today. The Ontario Health Coalition is Ontario's broadest public interest group regarding the public health care system. Our positions regarding this legislation have been come to by consulting with our members across the province, including residents' groups, patients' rights groups, seniors' organizations, unions that represent workers in long-term care, the nurses, health professionals' organizations—so the whole range of our membership.

We approve of some significant changes in this act, and I want to mention them, because I understand that there is a push from some of the provider organizations for fewer standards and less regulation. Actually, we definitely approve of the direction towards more regulation within the act. Specifically, we support the increased ability of residents to promote their rights contained in the bill of rights. We promote written sign-off of facility operators to confirm their review of admission documents. We support the proposed intent to limit casual and agency staff, although we'd like to see it stronger. We support the inclusion of an RN on-site 24/7, the increased powers of inspectors and the continuation of regular, unannounced inspections, which has been a

big improvement over the years of lack of inspections and orders in compliance.

In addition, we approve in principle of the idea of whistle-blower protection, but we are concerned, along with the unions and the seniors' groups, that the protections are insufficient, because a whistle-blower can still be fired for whistle-blowing. They'll have to grieve, if they have a union, or go to the labour board themselves, if they don't have a union, to get their jobs back. While there's no magic solution for this, it is a real financial barrier to whistle-blowing, and we'd like to see if there's some way to mitigate that somehow.

We also believe that the bill should be clear that gag orders and such clauses in employment contracts be unlawful, and that that be enforceable.

We'd also like to see that neglect should be defined so that facility operators and the government, who bear the majority of the decision-making power when it comes to things related to neglect—including assessment, spending decisions etc., which are critical to preventing neglect—actually have some way of being held accountable for those decisions.

For us, though, the really key issue that we're hearing about from everybody across the province regarding this legislation is that there just isn't enough time to provide care. From the families, we're hearing that they're hiring caregivers, if they can afford them, to provide additional care for their family members; for those who can't afford them, they're going without. The caregivers themselves are saying, as you've heard in great detail, that there just is not enough time to provide the care.

The types of care that people are going without are more than just superficial things. We're talking about feeding, in some cases, that there's not enough time to feed. That's a common complaint. There's not enough time to reposition. These are critical, preventive measures done by personal support workers, RPNs, the work that will stop dehydration, that will help to prevent bedsores and deterioration, and there isn't enough time to provide that care.

We believe that the key thing this act needs to deliver on is an assessment of what the needs are, what the population need is, some way to provide care to meet that assessed need, a minimum care standard, and funding that's aligned with meeting the assessed need of people in the facilities. If you look through the act, that piece isn't actually there. So while there are improvements in all kinds of different types of standards and regulations and enforcement and so on, that critical, core piece of measuring and trying to meet population need isn't actually there.

**1350**

We're not hearing this in specific localities around the province. I travel around the province about five times a year, to virtually every community, every 100,000-person town, and we're hearing it from absolutely everywhere in the province. So we believe that this is not a localized issue, that this is a systemic issue.



We also wish to note that this legislation isn't being written just for the term of this government, that it's being written for future governments, and that there is lots of concrete evidence of abuse in the past that needs to be addressed in the legislation.

We know, for example, that facility operators have practised removing elements from the accommodation envelope, which is the envelope from which the for-profits can take profit, moving them into the personal care envelope so that there's more room for profit-taking from the accommodation envelope. Those would be incontinence supplies, security, those sorts of things. We know that there was an announced direction to actually move those things back into the accommodation envelope, at least incontinence supplies, but we are now hearing that that hasn't actually happened.

We know that there have been chain-wide bankruptcies—all kinds of creditors left, the homes left.

We know that there have been awards of beds to for-profit operators that have been convicted of fraud and neglect in other jurisdictions.

We know that record profits are being reported at the same time as Natalie Babineau's story was being told in the *Toronto Star*, of a really horrific death due to a bedsore.

We know that there were years of inadequate numbers of inspections, few orders, unenforced orders etc.—a litany of these in media exposés. And we know that there has been tipping off of inspectors and tipping off of facilities, staffing-up before inspections and so on.

We believe that the act needs to at least protect against that type of abuse that has already happened or has happened over the last 15 years in the facilities. In order to address those situations, we have made a variety of recommendations in our brief, which I will go through as quickly as I can.

In addition to the minimum staffing standard, we're calling for 3.5 hours tied to the average—so a CMI of 100 would get 3.5 hours, increased for increased acuity, lowered for lower acuity. We're asking for the amendment in the legislation to be that cabinet is required to make a regulation introducing a minimum staffing standard, that the staffing standard actually be in the regulation.

We're asking also for an immediate update to the type of information that was in the PricewaterhouseCoopers report, so an assessment of comparative jurisdictions, the actual acuity, the actual staffing care levels currently.

We're asking for a review of the funding model to provide adequate resources to meet the assessed level of need.

We're also asking for support for public and non-profit care. In this month's *Canadian Medical Association Journal* commentary, they published new evidence from Canadian jurisdictions about the difference in spending decisions between non-profits and for-profits; it's in our brief. The basic gist of it is that the not-for-profits and public facilities provided more hours of direct care and made spending decisions more in line with the

public interest. So we believe the bill should be amended to require that the government increase the proportion of public and non-profit homes, that all new homes should be built in the public and non-profit sector, and that transfers from non-profits to for-profits should be disallowed.

We'd also like to promote accessibility. We'd like the reinstatement of the fundamental principle from the former acts, including that the physical, psychological, spiritual, cultural and social needs of the residents be adequately met.

Again, we believe that the funding must be assessed to meet assessed need and that the ratio of 60% basic accommodation should be reinstated.

We'd also like some protection in the act that charges for residents for basic accommodation not exceed CPP increases, to ensure that they stay affordable.

We are supporting the calls of the seniors' organizations for an ombudsperson's office, as opposed to the office of the long-term-care adviser.

We are supporting calls for a requirement for the director to pursue sanctions in sections 150 to 154. We think that the evidence of the years of non-pursual of sanctions is sufficient that the language should be stronger than "may" and should be "shall" in that section.

We believe that there needs to be a new section on democratic accountability and access to information and that that should include that nursing home operators should not be allowed to fund political parties and politicians nor give gifts to them. We note that with the homes for the aged, under the current salary disclosure legislation, they are required to disclose salaries; we think the for-profits should be as well.

There should be a sunset clause included in the legislation aimed at preventing the revolving door between the ministry, LHINs or any body that is created to form recommendations for health restructuring related to long-term care on the one hand and the nursing home industry on the other hand. We think there is sufficient evidence that that has happened. That should stop.

The ministry should be required to make public any past criminal or civil offences for fraud, neglect and abuse by nursing home operators applying to be awarded beds in Ontario. The requirement for public consultation on licensing must be accompanied by disclosure and access for the public to information regarding the proposal and the proponent. The public must have adequate access to documents in those licensing hearings.

The government must provide access to the information it collects regarding actual staffing and care levels. It's inexcusable that people have to pursue freedom-of-information requests to get that information, as has recently happened. It must make public the funding formula. The public must be given access to clear information delineating how much money each facility gets in each funding envelope and how much is spent in those funding envelopes.

We would like to see, in addition, a consultation process on the regulations. That's it.

**The Vice-Chair:** Thank you for your presentation. We have three minutes left. We can divide it equally among the three parties. We'll start with the Conservatives.

**Mr. Arnott:** Thank you very much for your presentation. I'm sorry I missed the first part. I had to go out to make a telephone call.

Your concluding comment that there needs to be greater consultation on the regulations is a very pertinent one. I would hope that the government will hear that request and respond with an appropriate process, assuming that this bill moves forward.

You brought forward a number of very important concerns. On behalf of our caucus, we express thanks for your presentation.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I want to focus on minimum staffing standards. The recommendations you gave to the committee closely follow the recommendations that were made in the Casa Verde inquest: firstly, to update the PricewaterhouseCoopers study; secondly, in the interim, to at least have a minimum staffing standard of 3.06 hours per resident per day; and then recommendation 30, that once the new study is done, the minimum staffing be changed so that it reflects the real needs and also is comparable to other jurisdictions.

Why is it so important to have minimum staffing standards, some staffing standards, with respect to hours of care per day per resident in this bill?

**Ms. Mehra:** We think it's critical because although right now there's increasing funding each year for long-term care and although it appears that the staffing is starting to go up—and that's important—this legislation is going to outlast any particular government. It's supposed to be for any government that comes in. The experience over the last 10 years has been that the staffing levels have fallen periodically to points that are simply critical and in fact dangerous for care. Moreover, the people who are responsible for the state of nursing homes in this province are not just the operators, are not just the caregivers in those facilities; it's also the government. We believe that the government should be held to account to provide enough resources to provide a reasonable level of care based on the evidence and based on the assessed need of the residents in the facilities.

**The Vice-Chair:** The parliamentary assistant.

**Ms. Smith:** Thanks. I note that you would like to see the fundamental principle changed. I would like to ask you to adopt the fundamental principle and start calling them homes instead of facilities.

Following up on what Ms. Martel had to say about the PricewaterhouseCoopers study, I just note that in the auditor's report of 2002, he noted that the report considered only the amount of care provided, not the quality of care, when looking at minimum standards. He also noted, "According to the consultants, the study's limitations included the facts that data for many of the comparative jurisdictions were gathered from three to five years earlier than the Ontario data and that 'several of the

jurisdictions were required to submit the data for funding purposes, which may influence data quality.'"

**1400**

The auditor had real skepticism with respect to the PricewaterhouseCoopers report, and I share his skepticism. I just wanted to put that on the record because you do reference it in your submission, and of course Ms. Martel has referenced it as well.

You had a concern around basic and preferred accommodation. Was that an amendment that you wanted to see in the legislation?

**Ms. Mehra:** Yes. It's in the brief.

Just to respond to the amounts of care, not the quality—the PricewaterhouseCoopers study. That was in 2001. If the government doesn't actually accept the comparability of the jurisdictions, we'd be happy to see the updated report with comparable jurisdictions that you think are actually comparable. It's now 2007. That hasn't been done, so there's a question about that. Also, it's pretty much accepted practice across North America now to go for care standards.

**The Vice-Chair:** Thank you very much for your presentation.

#### REGISTERED NURSES' ASSOCIATION OF ONTARIO

**The Vice-Chair:** The next presentation will be by the Registered Nurses' Association of Ontario. You can start whenever you are ready. Please state your name for Hansard.

**Ms. Joan Lesmond:** Good afternoon. Thank you for the opportunity to address the committee on this very important piece of legislation. My name is Joan Lesmond, and I am the immediate past president of the Registered Nurses' Association of Ontario. With me is Sheila Block, who is our director of health and medicine policy. While I will provide you with an overview of our position, I invite you to read our submission, which includes more detailed recommendations.

First, let me state that RNAO supports this bill and its principle that long-term-care facilities are residents' homes and should provide them with dignity, security and comfort. The association hopes this submission will help ensure the legislation does just that. We believe that long-term-care reform must occur with an overall seniors' strategy that focuses on health promotion and quality of life. This legislation should be guided by the values of healthy aging, aging in place and choice for older persons. In long-term care, that means having a resident-centred philosophy. To be truly so, long-term-care facilities need enough staff with the right training to provide effective, safe and culturally competent care.

One of the core values that drives RNAO's work is our support for not-for-profit health care delivery. This government has shown its commitment to medicare in many ways. However, in the long-term-care sector, there has been a trend towards increasing for-profit delivery. Since 2000, more than 65% of new beds in Ontario have



gone to for-profit facilities. The share of for-profit beds in this province now stands at 52%. This causes concern because there is considerable evidence that shows that not-for-profit homes provide better quality of care.

Therefore, we recommend three changes to the bill to strengthen its support of not-for-profit delivery:

(1) Include a commitment to uphold the Canada Health Act, and to promote and support not-for-profit long-term care in the preamble.

(2) Incorporate a governing principle to support not-for-profit ownership in the licensing section.

(3) Include a right of first refusal for not-for-profit homes when new beds are allocated.

There is no question that residents of long-term care are vulnerable and better protection and oversight are needed. That's why RNAO welcomes provisions in the bill that protect whistle-blowers, that protect residents' safety and security, and allow for creating the position of a resident and family adviser. But RNAO recommends that the bill go further and create an independent elder health ombudsperson office. This office could receive complaints from all seniors, not just those in long-term care.

While we support the proposed residents' bill of rights, we also recommend protecting both collective rights and individual rights, because one person's rights may conflict with the safety and well-being of others. We must also make sure those rights are not being violated. Bill 140 does require each facility to create a residents' council and, when requested, a family council. While RNAO supports these councils, we recommend the three following: first, funding them through a third party such as an elder health ombudsperson to make sure the councils are independent; second, allowing the councils to meet privately; and third, allowing the councils to speak with inspectors and have access to board minutes and copies of regulated standards.

The evidence clearly shows that the use of restraints has negative impacts, including loss of bone mass, muscle atrophy and emotional distress. As a result, we welcome measures in the bill that limit the use of restraints. However, we are concerned that the use of chemical restraint is not similarly limited, and we are concerned about the language of the bill on perimeter restrictions. As a result, we recommend that the requirement for a written restraint minimization policy include chemical restraints and we recommend that perimeter barriers be considered safety measures and suggest that the phrase, "unless the resident is prevented from leaving" be deleted from subsection 28(5).

The act clearly outlines these and a number of other measures to protect residents and improve care. We urge the government to work with home operators and consider their concerns to make sure the new requirements do not have any unintended impacts on resident care. We also recommend that the bill require full public consultations when making associated regulations. Any increased obligations resulting from Bill 140 must efficiently and effectively increase residents' quality of life.

We must also point out one glaring omission from the bill which is essential to improving residents' quality of life: a minimum standard of care. Until 1996, there was a minimum standard of 2.25 hours of care every day. It's time to bring back that standard and to improve on it. We strongly urge the government to set a minimum standard of care at 3.5 hours of care per resident per day.

Finally, nothing outlined in Bill 140 will improve quality of care without a strong commitment to provide adequate funding. There's a general consensus that this section is underfunded. Increasing demands on this sector without also increasing funding will have a negative impact on quality of care. If funds to meet new requirements for training, reporting and documentation are redirected from patient care, this bill will not live up to its promise. RNAO recommends that funding must be enhanced to cover costs of additional requirements imposed under Bill 140. Furthermore, we expect the government to keep its promise to increase spending by \$6,000 per resident per year.

I thank the committee for your attention. We look forward to working with you to ensure that the legislation provides Ontario's seniors with the best possible care. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We can divide it equally among the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation, specifically the recommendation about reinstating a minimum standard of care and that it be realistically set at 3.5 hours. Let me also ask about proposal number 9 to create an independent elder health ombudsman office. The government, instead of proposing an ombudsman, has talked about a resident adviser. I don't know if you want to make any comments about a resident adviser, but I wonder in this section, if it is not an independent health ombudsman office, would you also accept the proposal that the current ombudsman have oversight mandate both for long-term care and acute care hospitals? So if you can comment on the government's proposal for a resident adviser, which seems to take the place of an ombudsman, and why you think the ombudsman position would be more appropriate.

**1410**

**Ms. Lesmond:** I think the ombudsman position is much stronger to be able to effectively represent a long-term-care person in the environment. I think we really need to put what works as opposed to what looks like it's going to work, and we feel that would really create the level of accountability for the elder person.

**Ms. Martel:** So is it the independence from essentially the bureaucracy, the opportunity for that person to have independence, that's most important to you?

**Ms. Lesmond:** You've got that.

**Ms. Martel:** And you don't see that with the residents' adviser?

**Ms. Lesmond:** It depends if some of the same criteria for the ombudsman are expected in the residents' adviser, but I think the ombudsman is a stronger position because

of the independence and I think it also lets people be more comfortable to explicitly state what is happening with them. I don't know if you want to add anything to that, Sheila.

**Ms. Martel:** So people would be more forthcoming?

**Ms. Lesmond:** You've got it, yes.

**The Vice-Chair:** Thank you, Ms. Martel. Parliamentary assistant?

**Ms. Smith:** Yes. I was interested in some of your—sorry. Thank you for being here. I'm missing out on the niceties, I'm so entrenched in all of this.

I wanted to just follow up on some of your recommendations around resident and family councils. You set out a requirement that they meet in private. I believe that is already addressed in the legislation. We also restrict who is able to participate in family councils and residents' councils and exclude any staff except an assistant who is assigned to the resident council and who is—how do we put it?—acceptable to the council. So I believe those requirements that are already in sections 54 through 60 of the legislation address some of your concerns.

Were there more concerns around meeting privately? We also provide for the inspector to meet with the family council to discuss the report of the annual inspection, which I believe was your recommendation 12. Was there more to 10, 11 and 12 than those?

**Ms. Sheila Block:** I guess one of the things we're talking about is the independent flowing of funding in there, which you haven't necessarily addressed. Although you indicate that the assistant should be acceptable to the council, I think we want the opportunity for the councils to actually meet without that assistant, as might be needed.

Sorry, I think you had a third question but I can't recall what it was.

**Ms. Smith:** The act does provide for them to meet without any staff.

**Ms. Block:** Okay.

**Ms. Smith:** The other, with respect to the flowing of funds: The family councils project was funded independently and it's an organization outside of the Ministry of Health or outside of any long-term-care association. They receive funding from the province to run that. As far as family councils and residents' councils in homes are concerned, they are not funded by the ministry or the home; they are independent entities. That's the intention.

**Ms. Block:** Okay. Let me try and clarify, then. I guess we're saying that for them to function more independently and to function with strength, they need some funding, and that funding should be flowed through some independent body like that.

**The Vice-Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation. As always, it's well done. One of your recommendations speaks to the need to include both physical and chemical restraints in the requirement. I wonder if you want to explain the chemical and why you believe this is necessary.

**Ms. Lesmond:** I think chemical really is drugs, so sometimes the drugs can really have much more of a

negative effect. I think being conservative in both is what is really recommended.

**Mrs. Witmer:** Would you see that policy and procedure being very similar to the physical or is there a different process?

**Ms. Block:** Part of our concern comes from the specific exclusion of chemical restraints in the legislation, so I guess we have a concern that what could happen is, given that there isn't the constraint on the chemical restraints and there is one on physical restraints and the fact that chemical restraints can be less visible, there would be a bias in the legislation toward operators potentially using them. So in particular, we would want similar protections and we would also want a kind of joint decision-making process with the resident's substitute decision-maker or family in terms of an ongoing review of the use of those chemical restraints.

**Mrs. Witmer:** I guess the other question I would ask you is, we've heard from some people who work within the long-term-care environment that some of the enforcement requirements—the fact that people could be named and blamed etc.—would make that environment a less likely one where they might seek employment or others might go for employment. Would nurses be impacted by some of this legislation? Would there be less of a desire to work within this environment because of what is perceived to be a very punitive bill that focuses on punishment as opposed to continuous quality improvement?

**Ms. Block:** We have some suggestions. We think the strong enforcement in this bill is important and we support it. We have a couple of caveats on that, one of which is increased funding flow to be able to let people actually meet those requirements. We do have some concerns about not-for-profit board members in terms of some of the criminal and sizes of fines.

In terms of RNs or nurses, I think nurses want to work in high-quality environments where the quality of care is paramount. To the extent that this bill moves that forward, I think they'd be very supportive of it. We know that providers have some concerns and we believe that those concerns should be discussed and moved into regulation, making sure that any oversight is most efficient, most effective and targeted towards resident care. We think that a combination of government and home operators can try to work those through and make sure, but we do believe that the oversight in regulation is appropriate.

**The Vice-Chair:** Thank you very much for your presentation.

#### ONTARIO ASSOCIATION OF RESIDENTS' COUNCILS

**The Vice-Chair:** We move on. The next presentation will be by the Ontario Association of Residents' Councils. You can start whenever you are ready. The floor is yours.



**Ms. Patricia Prentice:** Thank you, Mr. Chairman. My name is Pat Prentice. I'm the executive director of the Ontario Association of Residents' Councils. I work for a board made up entirely of residents of long-term-care facilities across Ontario. The executive of the board met and spent the whole day reviewing the provisions of Bill 140 and have directed me to bring to you their thoughts and comments. They also wish to have me express to you their overall pleasure with what they have seen and their great pride in having an important part in the process. They were particularly pleased with the rights of residents being used as the framework and the attention to issues about which they had previously commented. In short they liked, for the most part, what they saw and they have very few suggestions, which could probably be regarded as tweaking.

In part II, regarding residents' rights, their comments on this section had to do with the emphasis on individual rights of residents. They believe that, at times, given the communal nature of homes, individual rights must bow to the rights of the group as a whole. They also were recalling with pride that nearly 25 years ago a previous board had written the very first publication of OARC and it was entitled Residents' Rights and Responsibilities. They believed then, and they do now, that rights also involve responsibilities to others, not just to their fellow residents but to staff and the administration of the home.

I'll deal with part IV, regarding councils. The executive, as you might imagine, spent a good deal of time on this section, pleased with its provisions and powers, save the requirement for residents' councils in each home. Much of this was carried over from previous legislation passed in the late 1980s. One provision that was carried over from that act is one that they would very much like to see removed from this act. It is subsection 54(2). It was, in their discussion, their strongest recommendation.

There has been provision since the previous act for membership in residents' councils, in addition to all residents, for substitute decision-makers for residents judged incompetent. Given the passage of years, and our experience with this provision, we believe that it is time to remove it. The provision has often been misinterpreted to mean any family member may be a member of residents' councils, including even holding office. In the 15 years that I have been associated with OARC, I have several times seen residents' councils literally destroyed because of an overzealous family member, no doubt meaning well but tending to take over from residents, many of whom did not wish to be told what to do by someone who did not share their lives and wishes. To be truthful, they resented them.

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Yes, this provision has been misunderstood at times and at other times has harmed residents' councils, but our major reason for asking for it to be removed is the wonderful growth and activity of family councils, a vehicle for interested family and friends of residents to make a real difference without infringing on the wishes and independence of residents. Our recommendation is in

fact a vote of confidence in family councils and how they can work for the benefit of everyone.

Under section 58, dealing with the powers of family councils, we ask that clause 58(1)4, the provision for family councils having the power to "attempt to resolve disputes between the licensee and residents," be removed. Board members see this as an unnecessary addition and, frankly, somewhat patronizing.

Both sections dealing with residents' councils and family councils include in their powers, with an added reference to section 146, the right to receive a copy of the reports of compliance advisers. That's lovely, and it's appreciated, but what would be even lovelier still, in the opinion of my board, would be to include a requirement for the compliance adviser, as part of the inspection, to meet with both the residents' council and the family council, if one is in place. What better way to gather information than to ask the people who are in the best position to comment? In this regard, we would also urge that the standards currently in place for residents' councils be a priority for review and updating so that they better match the provisions of this act and so that they would better bring a common understanding of what was required to all compliance advisers.

In other comments, they looked at part II, section 18, regarding the prevention of abuse, and immunity in reporting: They felt that staff who had been terminated for abuse, and the abuse shown to have occurred, should not be reinstated by any arbitration through the labour act but should, as they so simply put it, be "gone."

The provision for excepting residents who report abuse knowing the report to be false: They believe strongly that no such immunity for residents should be included. A false report by someone knowing it to be false is wrong, resident or anyone else.

Part II, subsection 28(5), regarding external barriers being a possible restraint: I visit a lot of homes, and most homes have some sort of coded entry and exit system. According to the wording of this provision, it could be considered a restraint if residents are prevented from leaving the home. This needs rewording to clarify what is meant.

Part V, section 72, made them smile. They couldn't count the number of board meetings over the years where they have repeatedly voiced concern about the overuse of agency and temporary staff, people who do not know the home nor do they know the residents. The practice can often lead to errors in care, mistaken identity errors, and a feeling by residents that they can't possibly get to know their caregivers as they wish to do.

Part IX, subsection 141(2) and section 142, regarding the possibility of less frequent inspections of some homes: The board members welcomed the change to unannounced annual inspections and would not like to see that policy changed in any way. They believe that it "keeps them on their toes." They would, as previously mentioned, welcome a provision for the inspection process to include a mandatory consultation with residents' councils, and updated and extended standards

for councils to assist compliance advisers. My own observation, after visits to many homes, is that I rarely hear that residents have had the opportunity to speak with their compliance adviser. In some cases, in fact they have met, but they have met with the administrator and senior staff in attendance to hear what the residents had to say. I can only guess how open the discussion might have been.

Part V, section 76: We are very pleased to see the provision for a comprehensive admission information package, including material not just about the home's residents' council, but why not material that the residents themselves have prepared for it to be involved? They know best the things they would like to have known when they came in. They would like to be involved in this in their individual homes.

Thank you for the opportunity to come and tell you about the things they would like to see changed, the things they welcome staying as they are, and their thoughts on the many things you have added to improve the quality of life for residents in our homes. It has made residents very proud to be a part of it all, having a voice throughout the process. We know that many people have spent many long hours of thought in drafting the proposed legislation and the lengthy and much-welcomed consultations that preceded it becoming words on paper. To the residents, they are welcome words.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We'll start with the parliamentary assistant.

**Ms. Smith:** Thank you, Pat, for taking the time and for all the work that you've done leading up to this. I was interested in a couple of things. I wanted to also put on the record the great work that your organization has done on a manual for residents' councils that you're providing to all of our homes across the province, so thank you for that, and what a great accomplishment that is. I know a lot of hours went into that.

You didn't comment on minimum standards or standards of staffing, as we've heard about from a lot of the other organizations that have come today. What would your organization's view be on minimum standards?

**Ms. Prentice:** They talked about them. They're looking at their own experiences in homes right across the province, and they're tending to look at this through their own eyes, which is fine. I might not have the same thoughts, since I don't live in one of the homes. But they feel that when you set minimum standards of hours of care and things like that, that number would fluctuate too much. You can't say that 3.5 hours is what I need this Tuesday and expect it to be the same as what I need next Tuesday, when I'm feeling a lot better, or when I'm feeling a lot worse because I've just found out my son is very ill. They would like to see the skilled judgment of staff, other than the barest of keeping of standards, to know when it's not enough and when it is.

**The Vice-Chair:** Thank you very much. Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation. I appreciate the summary of recommendations

and certainly agree that some of them are just pure common sense. I hope the government will take a look at 54, 55, 58 etc. But I want to ask you about section 18. You've indicated here that staff terminated for abuse, with abuse proven to have occurred, should not be reinstated by arbitration under the labour act. Can you expand on that? Why do you feel that's important? And I don't disagree, by the way.

**Ms. Prentice:** I think it arose because I have had, in the last year and a half, two people on my board who have been residents of a home where a situation occurred, shall we say. I didn't ask for a whole lot of details; I trusted their recounting that something happened, okay? They believed very strongly that once the abuse has been proven to have occurred, reinstating that staff person or that volunteer or whatever is not even possible given the residents' feeling that if there's smoke, there's fire, or that they would have difficulty working with other staff. In fact, I was quoting them directly when I said they believed they should be not reinstated, but gone.

**The Vice-Chair:** Thank you. Ms. Martel?

**Ms. Martel:** Thank you for your presentation. I followed it word for word. There was one paragraph that wasn't read into the record, and I wondered if there had been a change in the view of the members who sat to talk about this. It's on page 2. It says, on the middle of the page, "Towards the end of part II there is mention of the possibility of an 'Office of the Long-Term Care Homes Resident and Family Adviser,'" and that this would be a duplication and is unnecessary. Is that still the view, or has that view changed?

**Ms. Prentice:** Thank you for pointing it out. It's probably because I was quite nervous and left it out. They did look at this and entertained the idea, because I have a pretty smart board and they're all acquainted with the job of the Ombudsman. They felt that although the legislation is worded so that it may happen, it was completely unnecessary. They thought that in order to get expert advice you'd have to have a whole building full of experts. They believed that they already had access to expert advice to know what to do in a given circumstance, and that it would be a very costly duplication of what they already knew was available to them for the asking. Their summary comment on all that was, "Take the money and put it into resident care."

**Ms. Martel:** So they were—

**The Vice-Chair:** Thank you very much. There's no more time.

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#### ONTARIO DENTAL ASSOCIATION

**The Vice-Chair:** The next presentation will be by the Ontario Dental Association. You can start when you are ready. Please state your name for Hansard.

**Ms. Linda Samek:** I'm Linda Samek, director of professional affairs with the Ontario Dental Association.



With me today is Mr. Frank Bevilacqua, director of government relations.

The ODA has a long tradition of promoting access to oral health care for Ontarians. Of particular concern to the association and its members is the promotion and delivery of oral health care for the segment of the population that resides in long-term-care homes defined in Bill 140. The ODA observes that the initiatives behind Bill 140 include ensuring the best possible level of care for residents who live in Ontario's 618 long-term-care homes. However, Bill 140 has failed to ensure that residents will be provided with the appropriate mechanisms to access oral health care.

Research indicates that residents in long-term-care homes have significant oral health needs. To ensure that residents remain, to the extent possible, pain free, comfortable and are able to eat and interact with others, there is a need to take a comprehensive approach to the overall health and daily living needs of those residing within the long-term-care system. Such an approach relies on the use of multi-disciplinary teams and regular visits from outside or community-based health providers, such as the dentist and dental hygienist team, to augment existing facility services.

The ODA agrees that a long-term-care home should be deemed to be the home of its residents and that all long-term-care residents should live with dignity and in security, safety and comfort within their home. It is in this context that the ODA suggests that this principle also must embrace the concept of informed choice for all residents. This choice should include the ability of individual residents to access oral health care.

Given the significance of oral health care to overall health and the comfort and daily functioning of each individual, the ODA is surprised and concerned that the bill does not include any reference to dental care within the context of the residents' overall plan of care. The ODA believes that it is crucial for residents who are admitted to long-term-care homes to have a comprehensive oral health examination by a dentist to ensure that an oral health maintenance and/or treatment plan is available to the individual and that the resident has access to necessary oral health care as long as they reside within the home.

Residents should know of their right to be fully informed about their overall health status, including their oral health status. Even if the home is not directly involved in the provision of dental services, residents should know that it is their right to access oral health care from qualified dental professionals, including those community and/or family dentists. For those residents who do not have a regular dentist, the ODA encourages the promotion of access to information about dental care providers in the local community.

Given that many residents are frail, with multiple chronic health conditions, and on several medications a day, the ODA recommends that the act include an express requirement that at least one member of the Royal College of Dental Surgeons of Ontario be affili-

ated with each long-term-care home to ensure that residents are accessing appropriate dental care services.

Long-term care homes should:

- be required to include participation by dentists in the integrated health care planning and coordination for residents;

- be required to offer, and residents be strongly encouraged to have, a complete oral health examination, evaluation, diagnosis and treatment on entry to the residence and on a regular basis as appropriate and, as a minimum, yearly thereafter;

- be required to have available a room in which basic professional oral health care can be provided;

- be required to have ongoing in-service training for staff on preventive oral health care; and

- be required to include, as a minimum, a dentist as part of the resident's health care team.

The ODA is concerned about another aspect of the bill, and that is the application of the mandatory reporting requirements outlined under section 22. First, there is wide variation in professional misconduct regulations among the many regulated professions. Second, even within multi-disciplinary working relationships, individual providers may not have the expertise to be familiar with the competency requirements of a member of another profession. Third, it is not clear what burden of proof an individual must have to determine that "improper or incompetent treatment resulted in harm or a risk of harm." Fourth, the investigative procedures to be conducted under the legislative framework would be separate from any disciplinary proceedings required under the Regulated Health Professions Act, thereby duplicating, perhaps, the disciplinary process. Further, it is not clear that the proposed investigative process will include provisions for privacy, due process and other applicable safeguards currently entrenched in the RHPA. Finally, we question whether the director has the appropriate expertise to address concerns around competence of professionals.

For all of the reasons outlined, the ODA recommends that any such complaints should be directed to the applicable regulatory college.

With respect to prescribing and using physical restraints, the ODA recommends that dentists be included as persons who may order or approve restraining of a resident for the purpose of assessing and providing oral health care services.

Section 70 relates to the requirement for the medical director to consult with health professionals working within the home. This provision should be expanded to include health professionals working outside of the home—that is, within the community—on behalf of the resident. This reflects the fact that community providers, such as dentists, currently provide direct care to residents within a long-term-care home or outside the home at a private dental office, and this care should be recognized within the legislative framework and facilitated through regular interaction with the director of the home.

To summarize, while the ODA supports the spirit of the legislation, it is of the view that the bill would be

strengthened if greater protections were included for the purpose of ensuring improved access to oral health care for residents in long-term-care homes. ODA's survey of its members indicates that a significant number of dentists currently provide outreach services to those within the long-term-care home. Nonetheless, the complex needs of this patient group are underserved with respect to oral health care needs. Indeed, there are examples of dentists donating equipment to a health care room within a long-term-care home, providing oral health care services for an extended period of time, only to be asked to remove the equipment when there is an administrative change. These experiences indicate that legislative provisions are needed to reduce barriers to oral health.

The Ontario Dental Association and the Ontario Dental Hygienists' Association worked closely together over a significant portion of last year examining how dentists and dental hygienists might work better. This led to a May 2006 memorandum of understanding between the ODA and the ODHA, concluding, in part, that long-term-care residences require priority attention and that both the ODA and the ODHA are prepared to work with the Ontario government to advocate for appropriate legislation in this area, including the establishment of health care rooms that can be used to examine the oral health status of the patient and to deliver oral health services within an appropriate environment.

We would suggest that the timing for such legislative reform is here. Bill 140 is an appropriate avenue to facilitate the inclusion of these health rooms within the long-term-care home and to facilitate the delivery of needed oral health care through the multidisciplinary, collaborative team of dentists and dental hygienists working in these residences.

The ODA is grateful for this opportunity to present this submission, and if there are any questions, we'd be pleased to answer.

**The Vice-Chair:** Thank you very much for your presentation. We have five minutes left. We can divide them equally between the three parties. We'll start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. You are suggesting, then, that at a minimum, in each one of the long-term-care homes there would be one dentist who would be providing the oral health care?

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**Ms. Samek:** We believe this can be facilitated in many ways, but there needs to be an outreach with a dentist in the community so that they can coordinate that care, whether it's ad hoc, as an individual resident needs it, or it's on a regular basis within the home. But we want to ensure that there is that contact with a dentist in the community. These dentists are already, in many instances, trying to provide that care, but it is very difficult to facilitate.

**Mrs. Witmer:** Right, and you've indicated that you've worked with hygienists on this issue as well.

**Ms. Samek:** We have.

**Mrs. Witmer:** Perhaps you could just enlighten us—I think sometimes people forget that people of all ages probably have the same need for good oral health care. What issues could occur, what health problems might occur, if these residents don't have the oral health needs addressed?

**Ms. Samek:** I think a lot of this is daily functioning as well. We all know about pain, but then there is this daily living thing, about eating, that your oral health actually helps you, and your social interaction with others. So it's sometimes the way you look—you're embarrassed; it is sometimes because of the pain, which could cause you not only pain and discomfort, but some difficulty with actual eating and functioning.

**The Vice-Chair:** Thank you very much. Ms. Martel.

**Ms. Martel:** I apologize for being out of the room for part of the presentation, so I hope that I've picked most of it up. You express the concern that in a particular situation, or several situations, dentists had donated equipment to a health care room and then had been asked to remove it when there was an administrative change. So I understand that you want some kind of provision to protect against that. But in terms of the suggestion that there be health rooms within each long-term-care home, are you anticipating that the home would cover that cost, including the equipment? What's your suggestion in terms of how this will work?

**Ms. Samek:** I think there needs to be discussion about what would be seen to be a minimum, but the reality is there are other health care providers that often go into homes as well. I think of optometrists and others. What we're looking at is appropriate lighting, appropriate access to water, the need to ensure disinfection, sterilization, all of those kinds of things, and while you can do some things at bedside, you want to ensure that you have in fact a more optimum opportunity to do this. We're not asking the long-term-care home to put in dental equipment, because much of that is portable, but a place where the resident can be facilitated in terms of that care within the right type of environment.

**Ms. Martel:** So for them to have special consideration of an appropriate room and, within that room, appropriate access, whatever that may be—if you're in a wheelchair—that would allow services to still be provided. I don't have an idea of what the cost might be to do that, but I'm assuming that is not a high-budget item in terms of facilitating that, making it happen.

**Ms. Samek:** As you noted originally, we have many dentists who go in from the community and try to accommodate this on an ongoing basis, and because it's not a requirement, you can have—and it is a bit of a burden for the home to be able to ensure that patients are available, that you have the administration there, that you're looking at health care records, because they need all of that information. Those things become something that can say, "This is a barrier. We don't have to do it, so we're going to turn this room into something else," for that facility.

**The Vice-Chair:** Parliamentary assistant?



**Ms. Smith:** I understand from my dentist at home that there was a time in the late 1980s or early 1990s when equipment was donated and then rooms were converted later on. One of the concerns that I know I've heard in my community is about the availability of dentists to go into long-term-care homes, or their willingness to go in, from both the home perspective and from the dentists, who are very busy, and it is an extra burden on them to actually leave their place of practice to go into a home. I'd just like to hear your comments on that. It's one thing to put these kinds of requirements into legislation, but if we're not able to deliver on it, then it's a bit redundant.

**Ms. Samek:** In 2003, we actually surveyed our members to ask about their treatment for people with special needs, and that included the long-term-care population. In fact, we did put together a resource document to help facilitate them to go and do this work. We found that four in 10 of our members expressed that they were doing this or they had a strong interest in doing this. When you consider the small but significant and growing population of those in these facilities, we think it is something that's quite doable. In fact, when we've asked people to go out and find out what's happening in their community, in one area—I'm thinking off the top of my head it was Burlington—when they went out and made contact with each of the homes, they were in fact told that there is some type of arrangement with a dentist or a number of dentists to come in and care for their residents, so we know it's happening.

**The Vice-Chair:** Thank you very much for your presentation.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 79

**The Vice-Chair:** The next presentation will be by the Canadian Union of Public Employees, Local 79. Welcome. Please state your name before you start.

**Mr. Tim Maguire:** Tim Maguire. I'm the first vice-president of CUPE 79.

**Ms. Ann Dembinski:** Ann Dembinski, president of CUPE Local 79.

**The Vice-Chair:** You can start whenever you're ready.

**Ms. Dembinski:** On behalf of the executive of Local 79 and members of CUPE Local 79, we wish to thank the committee for the opportunity to speak to you today and to share Local 79's views with you on the proposed legislation referred to as Bill 140, the Long-Term Care Homes Act, 2007.

I just wanted to tell you a little bit about CUPE Local 79. We are the largest municipal local in Canada. We represent more than 18,000 full- and part-time employees. Our members work at the city of Toronto, Bridgepoint Hospital and the Toronto Community Housing Corp. They work in many locations, and part of where they work is in 10 of the city of Toronto homes for the aged.

We're here today because we recall the promise that Premier McGuinty made during the 2003 election campaign to reinstate a minimum standard of care and three baths per week for seniors living in long-term-care homes. CUPE Local 79 shares the concerns of our members working in the homes for the aged that this proposed new legislation does not deliver on that promise.

While supporting the intention of the bill to improve the long-term-care system, our members have expressed a variety of concerns, including diminishing funding for resident care. It is a fundamental principle set out in the proposed act, and the act states, that "a long-term care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort."

Local 79 could not agree more with those sentiments, yet this proposed legislation fails to set minimum staffing standards for long-term-care homes. Where, then, is this promised dignity, security, safety and comfort for our seniors? This proposed legislation, as it is currently written, will not enhance the lives of the frail and elderly who live in our long-term-care homes.

This proposed legislation fails to guarantee Premier McGuinty's promise from his first election that his government would invest an additional \$6,000 in care for every resident receiving nursing home care. The Ontario Association of Non-Profit Homes and Services for Seniors have done the research; this government has only raised the resident care amount by \$2,000. Improving resident care and services must be the first priority. Residents' needs come first. Despite the funding announcements by this government, the level of care being provided to residents is still not what it needs to be. The promise was for an additional \$6,000 for care, which means primarily nursing and personal care, but also programming and support services and food. That's where the need was and continues to be the greatest. Most of any increased funding has not been allocated to direct care and services. Only about a third of the total amount can be legitimately described as enhancing care. The provincial government has not provided adequate funding for required front-line staffing. Resident care suffers because there is not enough staff in many homes and the number of hours allocated to care is simply not enough. Heavy workloads mean that there is insufficient time for baths, foot care, appropriate food, recreation and exercise.

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This government has never addressed the findings of the 2001 PricewaterhouseCoopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs, including depression, cognitive impairment and behavioural problems.

Last spring, an Ontario coroner's jury made recommendations supporting a regulated standard of 3.06 hours of care per day per resident. Labour organizations, seniors' advocacy groups and the Ontario Health Coalition all agree that a minimum standard of 3.5 hours of

care per day per resident will ensure that a humane standard of living can be provided at all times to our seniors living in long-term-care facilities. Residents need hands-on care and they need a minimum standard of care. These seniors deserve nothing less.

Long-term care is already chronically underfunded. Bill 140 proposes a significant increase in directives. Long-term-care homes will be required to spend a great deal more of their limited resources on compliance and administration, with no additional funding. Establishing new requirements and standards without providing the appropriate funding does not appear to be a recipe for success.

Additionally, we're concerned that more than half of Ontario's publicly supported long-term-care beds are in for-profit homes. This gives Ontario the dubious distinction of supporting the highest number of for-profit beds in Canada using public funds—this despite the fact that for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope, even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing homes industry are in direct conflict with the public interest in accessible and affordable care. Bill 140 does nothing to change this.

In 1996, the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. This government must reinstate a care standard to improve quality of life in long-term-care homes. With the downloading of heavier-care patients from hospitals and mental health facilities and with the aging of residents, the standard must be modernized to meet today's care needs.

Based on research of standards in other jurisdictions across Canada and the US, 3.5 hours of care would be the minimum required in order that our seniors are properly cared for and are able to enjoy a well-deserved high quality of life. CUPE Local 79 strongly urges you to amend Bill 140 and introduce a minimum staffing standard of more than three hours of care per day per resident.

Part of Bill 140 must spell out a provincial funding model to ensure uniform provincial standards and accountability for public money in all homes—those run by non-profit and for-profit providers—that will assure Ontarians that their tax dollars are funding front-line care for seniors, not increasing profits. Bill 140 should reflect the government's unequivocal support for public health care, and amendments must be made to this legislation to ensure that public funds in Ontario do not continue to support the highest number of for-profit beds in Canada.

CUPE Local 79 believes that publicly funded long-term health care is best delivered in the public, not the private, sector. Superior health outcomes are the result when people, not profits, are the bottom line. The funding model must address the shortfall of approximately \$4,000 per resident, from the original promise of \$6,000 per resident.

CUPE Local 79 members working in the city of Toronto's homes for the aged are, we believe, among the best municipal workers in Canada. They are dedicated, hard-working, concerned individuals who truly care about the seniors whom they work with in these homes. Our workers and our seniors both need a Long-Term Care Homes Act that will ensure that, in the words of the act, "A long-term care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort."

Our seniors deserve nothing less. Do not fail them.

**The Vice-Chair:** Thank you for your presentation. We have about two minutes left. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I want to focus on minimum standards. There was an earlier suggestion that you shouldn't have minimum standards and it should be the staff in homes who are in the best position to determine what care is required for residents. I have no doubt that front-line staff are probably in the best position, but they certainly aren't in any position to allocate funds to have more staff to provide more care, and therein lies the dilemma. The government made a promise of \$6,000; they've funded about \$2,000 to date. The government made a promise to have minimum standards, and there are no standards. I think that the government should live up to both of those promises.

In your opinion, why do you need a minimum standard, and what is the result if you leave it up to workers to determine what kind of care is required without giving them the resultant money or authority to actually staff up to those needs?

**Ms. Dembinski:** Certainly, as president of Local 79, I'm in regular contact with our members in the homes for the aged. Many of our members—and I'm sure you know this—work in more than one facility. That's common knowledge. When I've been out and speaking to the members, I hear two different things. I hear about the difference that exists between municipally run homes for the aged—and I will say the city of Toronto—and the other homes they work in. Often our members in the homes—not the Toronto-run homes—are pressured to take shortcuts if they are required and, if it is left up to the staff, to decide how to do it.

**The Vice-Chair:** Thank you.

**Ms. Dembinski:** I—

**The Vice-Chair:** Sorry. The parliamentary assistant.

**Ms. Smith:** He's a taskmaster. Sorry about that. If you want to finish your answer, go ahead.

**Ms. Dembinski:** That's okay.

**Ms. Smith:** I appreciate your presentation today. I'm certainly familiar with the Metro homes, and I've visited a number of them.

**Ms. Dembinski:** It's the city of Toronto now.

**Ms. Smith:** Sorry.

**Ms. Dembinski:** They amalgamated.

**Ms. Smith:** Exactly. I get that in the ministry as well.



I appreciate your acknowledging the system improvements and some of the programs that we've introduced through our nursing strategy, our public reporting website, our complaints hotline, our assessment tools. We've also—and I don't know that it's acknowledged here—made some major investments in front-line workers, including 1,100 new nurses and about 3,800 other front-line workers.

I just wondered, regarding the assessment tool, if you were familiar with MDS—I think some of the city of Toronto homes have been early adopters—and whether or not you have any input from your membership on whether or not they feel that's going to be an improvement in the system.

**Ms. Dembinski:** In terms of the members, I can't say that our members are intimately familiar with it. I know the tool because I'm the president of the local. I think it hasn't got down to the level of front-line staff.

I would say that the local is hopeful that it will allow you to more correctly reflect the level of staffing that is needed. I'll speak for the homes for the aged, that in fact the level of care now is much, much heavier than when I first started dealing with the homes. I see people who have G tubes, who were never in the homes before. So it's very important that it's recognized that individuals who are extremely heavy, heavy care who are in the homes for the aged should in fact have additional funding.

1500

**The Acting Chair (Mr. Bob Delaney):** Thank you. That does pretty much conclude the time on that one. Mrs. Witmer?

**Mrs. Witmer:** Do you want to continue with your response to Ms. Martel?

**Ms. Dembinski:** Your question was front-line staff. Obviously, they are the ones who deliver the care. I will say, if you were to go and ask one of our members, "Do you think that this individual needs more care?"—our members want to give the best care possible to these seniors—the answer should be yes. But then, often they are faced with other pressures that come from administrators.

**The Acting Chair:** Thank you. I'm sorry, we have to conclude your presentation there.

#### DON MILLS FOUNDATION FOR SENIORS

**The Acting Chair:** The next presenter will be the Don Mills Foundation for Seniors, Mr. William Krever. Please be seated. Make yourself comfortable. Kindly begin by introducing yourselves for the purpose of Hansard. You'll have 15 minutes for your deputation. If you've been here for a little while, you generally pick up the protocol. Any time you leave remaining will be divided among the parties for questions. Proceed at your leisure.

**Mr. William Krever:** Thank you very much. My name is Bill Krever. I'm the president and chief executive officer of the Don Mills foundation. With me today

are Dorothy Pestell, the volunteer chair of the board of directors, and Bernita Borgh, vice-president of resident services and the administrator of Thompson House Home for the Aged.

First of all, thank you very much, on behalf of the foundation, for the opportunity to address the standing committee on social policy today. We're certainly very pleased to give our thoughts on Bill 140. First, I'd like to give you a very quick overview of the Don Mills foundation and some overall comments on Bill 140, and then turn things over to Dorothy Pestell, the chair of our board.

The Don Mills Foundation for Seniors provides a continuum of services for seniors in the Don Mills and surrounding area. This continuum includes Thompson House Home for the Aged, which is a 136-bed long-term-care home, E.P. Taylor Place Community Services and E.P. Taylor Place Senior Adult Centre. Thompson House opened in 1969 and has developed a strong reputation in the community for providing quality care to its residents and their families.

The Don Mills foundation is a not-for-profit charitable organization with a volunteer board of directors and a strong core group of more than 550 volunteers.

The Don Mills Foundation for Seniors has enjoyed a long and healthy partnership with the government of Ontario and the Ministry of Health over the past 38 years. Our board of directors fully endorses many of the principles contained in Bill 140 and we have always strived to maintain the quality of care for our residents that Bill 140 is trying to ensure.

Our association, the Ontario Association of Non-Profit Homes and Services for Seniors, will be providing a comprehensive critique of Bill 140 and they will be providing detailed recommendations for specific changes to the legislation. The Don Mills foundation is fully supportive of these recommendations put forward by OANHSS.

While the Don Mills foundation is supportive of the spirit of Bill 140, it is the application of the legislation that we are concerned about. In particular, we are concerned with the continued erosion of the not-for-profit sector in Ontario. From the dominance of the for-profit sector in the awarding of new beds in Ontario to the strict governance and accountability parameters contained in this legislation, the future of the not-for-profit sector is being seriously challenged.

At this point, I'll turn things over to Dorothy Pestell.

**Ms. Dorothy Pestell:** My name is Dorothy Pestell and I am the chair of the board of the Don Mills Foundation for Seniors. I would like to take a moment and share with you three important concerns that I have with regard to my position as chair of the board.

First of all, I am extremely concerned about the harsh penalties under Bill 140 that can be imposed on volunteer board members. When recruiting qualified professional members of the community to serve as board members, I am obligated to fully disclose all aspects of governance, and this, of course, includes any risk factors to new mem-

bers. A \$25,000 first-offence fine and possible imprisonment under this new legislation will certainly deter any prospective volunteer when the personal risk is so onerous. Canadian law does not allow insurance policies to cover these fines.

We don't live in Camelot. Our society and the people in it are not perfect. In spite of the best efforts and screening mechanisms of administrative staff, there is always the odd bad apple in the bunch. It happens in law enforcement, in the teaching profession and in other professions. You do your best. Mistakes, intentional or unintentional, are bound to happen, even in the tightest-run facility. Without the volunteers to form the board of directors, I'm not sure how our facility could operate.

Secondly, I'm concerned about the extra time required of our nurses and other health care workers. According to Bill 140, our nursing staff will be required to help residents in obtaining goods and services not provided by the home; number two, to monitor the lengthy periods of time residents who should be restrained for their own safety, as well as that of others, would require before being put into a safe, secure environment; and to develop and administer annually a satisfaction survey. These are just some of the extra items that are going to be required of the staff at Thompson House. At present, the nursing staff spends an inordinate amount of time on paperwork instead of being able to look after the people they're supposed to help.

Just projecting down in 10 years' time, 10 years from now a much greater percentage of our population will be over the age of 80. In addition to that, there will be fewer citizens in the workforce to support this substantial percentage increase. In 10 years' time, because there will likely be little or no funding to support the requirements of Bill 140, some long-term-care facilities will close, and they'll be forced to close. As well as existing residents, there will be substantially more over 80 who will need care. We're not sure where they will go.

The Don Mills foundation is very supportive of the implementation of a licensing program for the not-for-profit sector. However, fixed-term licensing tied to structural compliance will make it much more difficult to obtain financing for long-term improvements and will not solve financing issues for the not-for-profit sector. This issue is further compounded by the fact that not-for-profit organizations will only be able to sell or transfer beds to other not-for-profit organizations. There is no such restriction in place for for-profit operators. While this provision may appear to protect the balance of not-for-profit beds, it will erode the financial strength of the not-for-profit sector.

I'm going to turn it back to Bill now for a few moments.

**Mr. Krever:** Just a couple of comments from our perspective on the increased accountability: The Don Mills foundation fully supports accountability within the long-term-care sector, and we have a proven track record of meeting and, we think, exceeding the standards as set by the province of Ontario. However, Bill 140 proposes a

regulatory environment that will be much more prescriptive and micromanaged by the Ministry of Health. It is certainly necessary to address the small percentage of long-term-care homes that are not meeting the standards of care as set out by the Ministry of Health. However, we feel it is equally important to provide incentives for those organizations that have consistently exceeded these standards.

It should be further noted that the proposed accountability framework through Bill 140 is adding a heavy burden on long-term-care homes in terms of staff resources. Current funding levels have not been increased to cover the resources needed for this increased accountability. This burden is ultimately taking resources away from direct resident care.

At this point, I'll turn it over to Dorothy for our closing comments.

**Ms. Pestell:** As a volunteer leader actively involved in the not-for-profit long-term-care facility, I support many of the concepts of Bill 140. However, I am disheartened that this legislation fails to provide adequate recognition of the dedicated work that volunteers are doing throughout the province in caring for seniors in our community.

More importantly, I'm gravely concerned that not only does Bill 140 do nothing to ensure the future of not-for-profit long-term care in Ontario; it also creates new barriers with which we must deal.

**1510**

In closing, I would ask the standing committee to take a close look at the impact that you're having on the not-for-profit sector through this legislation. Our association, the Ontario Association of Non-Profit Homes and Services for Seniors, has provided specific recommendations that should be carefully considered by this committee.

Finally, I would ask the standing committee to also consider the opportunity that lies before you to truly send a message on the value of the voluntary sector in Ontario. This is your opportunity to demonstrate your commitment to volunteer leaders in communities throughout Ontario.

Thank you for allowing us this opportunity to present our concerns.

**The Acting Chair:** Thank you very much. We should have time for about one minute from each caucus for a brief question, beginning with Ms. Smith.

**Ms. Smith:** Thank you for being here and for your work in this sector. In your presentation, you talked about the not-for-profit sector being largely ignored in the awarding of new long-term-care beds in the recent redevelopment. Why do you think that was, if you want to comment further on that?

**Mr. Krever:** I believe the balance was about 65% to the for-profit sector and 35% for the not-for-profit sector. So again, this is eroding the balance that had existed previously.

**Ms. Bernita Borgh:** I think too, being a charity, we actually did put in for beds, so we had to do proposals on our own. I know that the large chains have head offices with large groups of people who can help them with



these types of proposals. In our instance, we wrote it ourselves and we weren't awarded the beds. I think that the charitable homes have put in proposals, but we're at that disadvantage.

**The Acting Chair:** Thank you. Ms. Witmer.

**Mrs. Witmer:** I had a question in here about the not-for-profits. You indicated, and as we know, that you're only able to sell or transfer your beds to other not-for-profits. Then you indicate that there's no restriction, of course, for the for-profit. You say, "While this provision may appear to protect the balance of not-for-profit beds, it will erode the financial strength of the sector." Could you explain that for me? I suspect the government thought that they were protecting the not-for-profit sector, but you're saying it will erode the financial strength.

**Mr. Krever:** Certainly. I think one of the concerns would be, as a not-for-profit provider, that if you're only able to sell your beds to another not-for-profit organization, the market is very limited in terms of who could buy those beds, whereas if you can sell to the whole market, the value is much greater. So that in itself, I think, would devalue the for-profit beds. I also think it could have an impact in terms of the ability of homes to get financing based on those licences to rebuild, because of the devaluing.

**Mrs. Witmer:** From the financial institutions, you're talking about?

**Mr. Krever:** Yes, that's correct.

**Ms. Martel:** Thank you for your presentation. You have a 136-bed home and you said you're a C home. You have three- and four-bed wards now?

**Ms. Borgh:** All two-bed rooms—we have two four-bed rooms in the entire building.

**Ms. Martel:** And those would have to be upgraded and modified. Have you had a costing for those?

**Ms. Borgh:** Actually, the whole building would have to be, because we're a C facility, and because it's not just the rooms that are considered in a C; there are common areas. We have residents who have to go down to a main dining room in the lower level, so it's transporting them on elevators when they're a higher level of care than when they first came in. Normally, there were 70-year-olds who were coming in 1969, and now we're getting 90-year-olds. So it's more than just the rooms. We only have two rooms that are four beds, but also our two-bed rooms are the square footage that the new standard is requiring for a single. So basically, in all of our rooms, we would have half the population. We have had different proposals, architects look at it, and we could actually facilitate 52 seniors in our building instead of 136 if we applied the new standards to them.

**Ms. Martel:** So for you to do a conversion, have you done an estimate on the cost?

**Ms. Borgh:** We'd have to do a whole rebuild. We're at the \$22-million mark. That would cost—

**Ms. Martel:** So you're not really in a position to do that all on your own out in the market.

**Ms. Borgh:** Exactly.

**The Acting Chair:** Thank you very much for having come in today and for making your presentation before us.

## VON ONTARIO

**The Acting Chair:** I'm advised by the clerk that the deputation originally scheduled at 3:15 has been cancelled. I now ask VON Ontario, Mr. Paul Ting, to come forward. Good afternoon and welcome. You'll have 15 minutes to make your deputation before us. If you leave any time remaining, it will be divided among the three parties for questions. Please begin by stating your name for Hansard and then proceed.

**Mr. Paul Ting:** Good afternoon, ladies and gentlemen. My name is Paul Ting. I'm vice-president of operations for VON in Ontario. Thank you for the opportunity to speak with you today about VON's concerns and recommendations respecting the draft legislation on long-term-care homes in Ontario. The standing committee on social policy is to be commended for bringing forward recommendations that will ensure the appropriateness and adequacy of care provided in long-term-care facilities.

VON has been providing home and community care in Ontario for more than 108 years. We have a very distinguished record through various well-known and respected services, such as home nursing and support, health promotion, and the delivery of charitable programs like Meals on Wheels, volunteer transportation and exercise for seniors. We have 22 branches delivering care and support in Ontario.

The high-quality services we provide are intended to keep people living independently in their homes and communities and out of long-term-care facilities and hospitals for as long as possible. We know that Ontarians prefer to receive care in the comfort of their own homes, surrounded by their family, friends and neighbours. With that perspective, we offer the following comments and recommendations.

(1) Home and community care: Some people would say that the health care system in Ontario is in distress, with a shortage of hospital beds, a shortage of long-term-care beds, emergency departments that are overflowing and a shortage of family physicians. These issues must be addressed, but VON struggles to understand why more focus, energy and funding have not gone into the home and community sector, where, according to Roy Romanow's final report, "growing evidence [suggests] that investing in home care can save money while improving care and the quality of life for people who would otherwise be hospitalized or institutionalized in long-term-care facilities."

We raise two issues here. First, the standing committee on social policy should take the responsibility to regroup, following implementation of this legislation, to discuss and draft new legislation that would address the need for more resources in the home and community sector, where more and more Ontarians wish to receive

care and where it is more cost effective. Second, the current draft legislation should ensure that Ontarians are aware of their home and community care options prior to applying to long-term-care facilities and during the assessment to determine eligibility to a long-term-care facility. Therefore, VON's recommendations are as follows:

VON recommends that a clause be added to part II, subsection 41(4), to allow a comprehensive and thorough discussion of the home and community support options prior to considering a long-term-care facility.

VON recommends that follow-up legislation to Bill 140 be drafted to include appropriate and adequate financial and human resources in the home and community sector to support people safely in their own homes and communities.

(2) **Caregivers:** Caregivers are individuals who provide care and assistance for their family members and friends who are in need of support because of fiscal, cognitive or mental health conditions. VON has been championing recognition and support on behalf of almost three million caregivers in Canada, because these individuals play a crucial role in our health care system. Caregivers are not paid and often incur their own stresses, both financial and emotional. They provide more than two billion hours of caregiving each year, saving the Canadian health care system approximately \$5 billion a year. Caregivers keep their family members, friends and neighbours in the community and home—where they want to be—and out of institutions as long as possible. Caregivers need to be recognized as valuable contributors to the health system, and so we have the following recommendation.

**1520**

VON recommends that Bill 140 recognize and define the term “caregiver” under “Interpretation” and the valuable role they play and include the term, where appropriate, within the draft legislation. We have the full description within our written submission.

Finally, third, not-for-profits: The value of not-for-profit organizations should not be understated. As a not-for-profit charitable organization, VON knows the value added for communities, across Canada, across Ontario. When VON is in your community, you not only benefit from the program and services for which we are contracted to deliver, but we also assess the local health and social needs and work with community partners to fulfill these needs.

VON supports the thousands of volunteers who make things happen in local communities, and we support the important role of not-for-profit long-term-care homes. VON recommends that the standing committee on social policy include a stronger commitment to preserve and promote not-for-profit delivery of long-term care for the benefit of Ontarians.

Thank you very much for giving VON Ontario time to speak today.

**The Acting Chair:** Thank you very much. Your very concise brief has actually left some meaningful time for

exploratory questions, beginning with Ms. Witmer and Mr. Arnott.

**Mrs. Witmer:** Thank you very much for your presentation. I do appreciate particularly your first recommendation. I agree with you very strongly that we need to take a look at what options are available to people prior to going to a long-term-care facility. I do believe that if we were to provide the additional financial and human resources, many of those individuals could stay in their own homes, which is obviously the preference of most individuals. I guess, as well, we could be keeping many more people out of the hospital, again, if we were to look at the community care services that would be available to people, and we wouldn't have some of the problems we're experiencing today in the hospitals with the emergency room crisis.

I think that's an excellent recommendation, and I think it's part of an overall strategy that the government needs to look at as to how we can best ensure that people are accommodated most appropriately. So I thank you for bringing that forward.

I guess you've also recognized that in order to do this, we do need more finances and we do need more human resources to keep people safe in their homes.

I'm curious, and I'm going to ask you—I see this push towards the not-for-profit. I guess right now we've got a degree of balance within the system. I think sometimes that push and pull is kind of healthy; it keeps everybody honest, hopefully, and on their toes in providing the best services to people. Why do you feel so strongly about this, Mr. Ting?

**Mr. Ting:** I feel so strongly because of the nature of not-for-profit organizations. Their mission and their value are to provide services. If there is any surplus at the end of the day, we invest it in the organization to further enhance the services. The nature of that mission and the mandate and the way they organize themselves to do that, I believe, preserve the integrity of what the funding is intended to do to benefit Ontarians to the fullest extent. I believe the not-for-profit organizations leverage significantly one of the three recommendations I made, about volunteers, in terms of the role the volunteers play within the not-for-profit system. I think not-for-profit organizations do embrace that and work towards the best value for Ontarians using the volunteer sector, using the dollar invested by government and then stretching them to the fullest extent.

**The Vice-Chair (Mr. Khalil Ramal):** Ms. Martel.

**Ms. Martel:** Thank you for your presentation. Let me add that the other reason you want to see it in the hands of not-for-profits is because some of the money that could go to patient care in a for-profit setting ends up going into the profit line instead of patient care. So that's the other reason why you want to see it in the hands of the not-for-profit.

**Mr. Ting:** Absolutely.

**Ms. Martel:** We did have a significant VON presence in our community—I'm from Sudbury—until, under the cutthroat bidding process in home care, the VON lost the nursing contract to a for-profit, private company that



didn't even have an office in our community. This whole issue of for-profit versus not-for-profit is a significant one, not just in home care but also in long-term care, so I am very supportive of the philosophy that you've brought forward—and RNAO and others have today as well—that we should be indicating in this legislation a much more significant support for the not-for-profit sector if we believe in it and if we want to see it continue, not just next year but in the years to come.

I think it will be interesting to see, on the RFPs that are out now for long-term-care beds, who's going to get those. We will all be looking with great interest to see who is awarded those beds.

One question that I wanted to ask you with respect to, on your first page, when you talked about the discussion that should be had with clients etc. about appropriate supports and services, is, is it your view that in most communities the community supports would be in place to actually allow that option to be a real one? That would certainly be a concern that I would have, that you could have that discussion, but in fact the community supports aren't actually in place to allow that to be a viable option for those who are needing additional services.

**Mr. Ting:** Obviously by that recommendation I have the underlying assumption that the government places the value of home care as a critical part of the health care system and that that will be funded and structured effectively to provide that option in terms of the family who prefers to be cared for at home rather than in the long-term-care institution. You're right: Depending on different parts of Ontario, the funding level is different. We would hope that in time we will have adequate support for the options chosen by the family, maybe home care, long-term care or otherwise.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** Thank you for being here. I appreciate hearing your report today. I heard a lot about aging in place and aging at home when I did my initial review of long-term care just after being elected, so late December 2003 into 2004. Certainly a number of the groups that we spoke to talked about the need for aging in place and the benefits that had for the senior and the family and everyone concerned. I also heard first hand about the cuts of the previous government when I was knocking on doors in 2003, and what impact that had on seniors who were forced to go into long-term care before they really needed to because there was that little bit of support lacking in their life. We have tried to address that as a government through an increase of about \$340 million in home care over the last couple of years. We continue to make those investments, and we do recognize the importance of aging in place. I just want to acknowledge that.

I did want to ask you about your caregiver requirement and including the caregiver in the definition of family council members; at least I think that's what you were getting at. In the family council section as it's now written, we allow as a right a member to be a family member of a resident or a former resident or a person of importance to a resident or former resident. I just wondered if the "person of importance to a resident"

wouldn't capture the caregiver, wouldn't satisfy what I believe is your request to have caregivers included in family councils.

**Mr. Ting:** I think that recommendation is really in the context of the first recommendation that I made in terms of the options made available to those who choose to receive care at home. The caregivers in fact play a large role in that respect. Even if someone is a resident in the long-term-care facility, the family members or friends do play a role in terms of providing that peace of mind to the residents in terms of checking in, in terms of visitation and so forth. That aspect is still very significant in terms of that connectedness, even though that individual is placed in a home, still being connected to the broader network of friends and family.

I'm not expert in the legislation drafted in terms of which section in that context is best to be incorporated. I'll leave it to the experts to do that, but I just wanted to put forward the notion that caregiver is an important role in the health care system, even in this context.

**The Vice-Chair:** Thank you very much for your presentation.

1530

#### ONTARIO SOCIETY (COALITION) OF SENIOR CITIZENS' ORGANIZATIONS

**The Vice-Chair:** The last presentation will be from the Ontario Society (Coalition) of Senior Citizens' Organizations. Welcome. You can start whenever you're ready.

**Ms. Judith Jordan-Austin:** Thank you for sticking it out for this time of day. We're happy to be able to be here with you.

I'm Judith Jordan-Austin. This is Ethel Meade. We are representing both Care Watch and the Ontario Society (Coalition) of Senior Citizens' Organizations. For those of you who may not be familiar with Care Watch, it is a volunteer organization primarily concerned with quality care in the home or in the community for frail senior elders. I hope that is enough of an introduction.

OCSCO represents 150 organizational affiliates representing more than half a million Ontario seniors. We thank you and commend you on Bill 140 and the measures taken to improve Ontario's long-term-care system.

Ethel, do you want to continue?

**Ms. Ethel Meade:** Yes. We certainly have a very positive attitude toward this bill. We think it expresses a great deal of very good intentions in the long-term-care field. We do have some questions and I have to tell you that the very first one is, since the bill itself is in general terms, the nitty-gritty, the way that things are going to be done, the whole process of making these changes come about is going to be in regulations. We're very concerned that there will be public consultation on the regulations, at least 60 days, and as wide an opportunity as possible to make submissions.

**Ms. Jordan-Austin:** May I just add at this point that I would emphasize the fact that we are representing consumers, people who actually will need this kind of care.

**Ms. Meade:** It could happen to any of us any day.

We are also concerned with the bill of rights, which is an excellent list of rights but it's missing one thing that we consider very important, and that is the right to receive the care that you actually need. We know that we don't have that kind of right under the Canada Health Act; we only have the right to a fair share of what's going. But we think for our seniors, in their very last years, we owe it to them that they do receive the care that they've been assessed to need. That is one of our first questions and, along with it, will there be enough funding to actually bring about the changes that we need to get to this right of care?

We and other organizations have thought about and talked about, many times, staffing ratios for long-term-care homes. Staffing ratios are the surest way, as far as we can see, to make sure there is enough staff to provide the care that's needed. Understaffing in long-term-care homes has a long history. It goes back as far as I can remember and it's not mainly because long-term-care homes are laying off their staff; it's because the people who are in long-term-care homes are older and more frail than they were a decade ago, so the acuity level has gone up in all homes across the province.

When we did have this kind of ratio, it was 2.25 hours of care, on average, for each resident. At that time, 2.25 hours of care may have been sufficient, but it is not sufficient today with the sicker and older people we have. Front-line workers tell us that 3.5 hours would just barely avert disaster. We really need more than 3.5, but 3.5 would be an improvement on what we have now.

We're very happy that a couple of important things have already been put into effect, like the unannounced inspections and the requirement for a full-time regular nurse to be on duty 24/7. We do want to ask whether the RN on duty will be considered to be fulfilling this if she has another obligation as well. If she is director of care or administrator and has any other obligations or responsibilities, we don't think that she can be counted as the RN on duty. The RN on duty should be completely available to patients, to people there, for interventions, for treatments and, above all, for looking at them to see how they're doing. The nurse should be available every hour of the day for any of the needs of the residents of the home. So we hope that they would not accept somebody just having RN qualifications as having an RN on duty.

We also want to ask about people who do the annual assessing of patients' acuity and the unannounced inspections. We would like to see both the inspectors and the assessors be mandated to speak to at least a random sample of the residents and their families and the front-line staff. That way, the inspections will be more real; we'll know more about what's really going on. Just looking at charts has never been enough. We hope that these people will be not only permitted but mandated to talk to people there, not just talk to the office and get the charts.

The other big thing we're worried about is the complaints procedure. I have to say that my experience with Queen's Park is that it still underestimates the fear that

people have of complaining. If you are dependent on somebody else for anything important, you will be afraid to complain about that person. You may be more afraid, you may be less afraid, probably in proportion to how much you depend on the service, but seniors of the age and fragility that we know are now in these homes are much more afraid than anybody seems to realize. And I think that applies also to the staff. It's very nice to have whistle-blower protection, but the staff has its own reasons for being afraid to report, and especially because the bill says any retaliation problems have to go to the Ontario Labour Relations Board. That too doesn't give very much confidence that they are really safe to make a complaint. I will repeat what we've been saying for years and years: We need an arm's-length commission that is not set up by the ministry, that is completely independent and reports to the Legislature, and we need really heavy advertising to let people know that this venue is available.

**1540**

It's shocking how much people don't know about what governments are doing. I would say, if you walked down the street and asked 10 people, "Do you know what a CCAC is?" or even if you said "community care access centre," very few of them would know. With all of the push there's been to try to get people to know that's available, the vast majority of people don't know. The same will apply to any commission that you set up to receive complaints. Unless there is really unprecedented heavy advertising, dramatic advertising—TV, radio, everything you can think of—then neither the independent commission we're asking for nor the info hotline that has been established is going to get the calls they should be getting. It has to be proved to people, and it has to be very, very public, that this is something that really is safe to do.

The next thing I just want to highlight is the question of what happens to the new long-term-care beds that were built with public money. Two thirds of that public money went to for-profit owners. We think that for-profit owners who have had the benefit of construction charges from the public should not be allowed to sell those beds to another for-profit operator. They should either return to the public or to a non-profit organization. We do feel very strongly about that. We never liked the idea that the public money was building private facilities in the first place, but we certainly don't want to see any extension of that.

I think I'll stop there. Do you want to add anything?

**Ms. Jordan-Austin:** We would prefer that the proportion of basic to preferred accommodation beds be set at 60% to 40% preferred, or at the very least a ratio of half and half. One rather interesting thing that we're suggesting is that the posting of information addressed to residents be mandated to appear in the 16-point sans font, like this one.

We are very concerned about the quality of care, of course. Perhaps you have some questions of us.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can divide



them equally between the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thanks to both of you for your presentation. It's good to see you out again. I just want to focus on the section about an Ombudsman-like office for senior care, which you have highlighted. Do you have a preference for a separate office, independent of government, for senior care? Or could your concerns also be met by having the current Ombudsman have oversight? Because he now reports directly to the assembly as well. What are your thoughts on that matter?

**Ms. Jordan-Austin:** I think we would prefer a totally separate arm's-length relationship, not using the Ombudsman who is presently in place but another one strictly for health and complaints of abuse and neglect and so on.

**Ms. Martel:** Would that include care in long-term-care homes and the acute care sector?

**Ms. Meade:** We would hope that it would deal with all senior care, including community-based care as well as institutional care.

**Ms. Martel:** I understand your distinction. I appreciate that.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** I have a couple of answers to some of your questions, but I wanted to just follow up on that question quickly. Would you foresee that this role would be one of advocacy or more one of investigation after a complaint or an issue has arisen? The way the long-term-care adviser is structured now, they would be providing assistance and advocacy for residents and their family members, but an ombudsperson has more of an investigative role that would look at issues after they've happened. I just wonder if that's what you're looking for.

**Ms. Meade:** We really would like to see those functions combined.

**Ms. Jordan-Austin:** They're not mutually exclusive. There's no reason why it couldn't be both.

**Ms. Smith:** Some would argue that they are mutually exclusive, but okay, we can debate that. I just wanted to let you know that your concern around the RN in the home having dual roles is addressed in subsection 7(4), where the same person who is acting as the RN cannot also be the administrator or director of nursing, so that role is separate. You asked about public consultation on proposed regulations, and that will be undertaken.

I'm running out of time, aren't I, Mr. Chair? Sorry, there were a couple of other issues that you addressed that I'll try to get you some responses to as well. Thank you for being here. Thanks for all your help leading up to today as well.

**The Vice-Chair:** Thank you very much. Mrs. Witmer?

**Mrs. Witmer:** I'd like to thank you for your very thoughtful presentation. What you've done here is to go through the bill from the perspective of those who are going to be impacted and I think very thoughtfully raised some questions and provided some suggestions. I hope that as we take a look at introducing amendments, we can take this into consideration.

You spoke about the resident bill of rights, and then you indicated that there should be the right to receive care that meets the assessed needs of each resident; you believe that should be a fundamental right. Whom do you see doing the assessment and how do you see those needs being addressed totally—obviously, it's going to require additional financial and human resources to do this—and how would it be enforced, too?

**Ms. Meade:** I've lost it.

**Mrs. Witmer:** Okay. The whole issue of the fact that the right to receive care that meets the assessed needs is a fundamental right: Who would do the assessment, how would the needs be provided for and how would it be enforced?

**Ms. Meade:** The first assessment is obviously done by the placement coordinator where the vet's going to be. The bill doesn't say if it's going to be the community care access centres or not. It used to be an independent function. I wouldn't at all mind seeing it go back to that. The second assessment surely is made when the person has entered the home. The home would want to make sure they know exactly what they have to deal with, and as we understand it, there are annual assessments of the acuity levels in every home. With the good intentions of this bill, we hope that assessors are not going to try to play down the acuity of the case but will instead be very open and honest about it, and the public will have access to those assessments.

We don't have a situation like we had 10 years ago or so when there was standard staffing for 2.25 hours. There was a big study done by Coopers and Lybrand—Pricewaterhouse—that came up with the fact that even with the 2.25 hours of required staffing, patients were getting less than that; they were getting 2.03 hours, on average. The question of enough staff to do what needs to be done is extremely important.

**Mrs. Witmer:** Thank you.

**The Vice-Chair:** Thank you very much for your presentation.

I want to thank everyone for a wonderful day and I everyone that tomorrow our meeting will be in room 151. Now we adjourn until tomorrow at 9 o'clock. Thank you.

*The committee adjourned at 1549.*





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Second Session, 38<sup>th</sup> Parliament

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Deuxième session, 38<sup>e</sup> législature

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Wednesday 17 January 2007

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Mercredi 17 janvier 2007

**Standing committee on  
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Long-Term Care  
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**Comité permanent de  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Wednesday 17 January 2007

Mercredi 17 janvier 2007

*The committee met at 0906 in room 151.*LONG-TERM CARE HOMES ACT, 2007  
LOI DE 2007 SUR LES FOYERS DE SOINS  
DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

**The Vice-Chair (Mr. Khalil Ramal):** Good morning, ladies and gentlemen. It's the second day of hearings for the standing committee on social policy. We're dealing with Bill 140, An Act respecting long-term care homes.

MULTIPLE SCLEROSIS SOCIETY  
OF CANADA, ONTARIO DIVISION

**The Vice-Chair:** We have several presentations for the day. We're going to start today with the Multiple Sclerosis Society of Canada, Ontario division. If they are here, they can come. I wonder if you know the procedure.

**Ms. Deanna Groetzinger:** Yes.

**The Vice-Chair:** Okay, then. You can start when you're ready. You have 15 minutes; you can split it the way you want. Please state your names before you start.

**Mr. John Clifford:** Thank you for the opportunity to present the views of the Multiple Sclerosis Society of Canada, Ontario division, on the proposed changes to Ontario's long-term-care system. My name is John Clifford and I am chair of the Ontario government relations and community social action committee of the MS Society. With me is Deanna Groetzinger, MS Society vice-president of government relations.

The MS Society is pleased that the legislation governing Ontario's long-term-care homes is being updated and consolidated through Bill 140. It is vital that our most vulnerable Ontarians receive the best care and protection possible. While many of the proposed changes are good ones, the MS Society believes there is a serious oversight in Bill 140, and that is that the proposed legislation does not contain any provisions that would facilitate the development and delivery of age-appropriate care within long-term-care homes.

Why age-appropriate long-term care? Well, let me tell you about several people with MS and their experiences with the current system. Their stories, unfortunately, are repeated every day across Ontario.

There is a young man with MS who lives in Kingston. He is now 30 years old but has been living in a long-term-care home for more than four years. He is severely disabled because of MS and needs considerable care. Unfortunately, his mother has her own health problems, his father is dead, and there are no other family members to assist him. He desperately wants to leave the facility and live in the community with assistance from home care and other services. He points out that even though the facility is supposed to be his home, he can't have a nap when he needs one during the day. MS can cause severe fatigue, but he has been told that if he lies down in the afternoon for a nap, he would have to stay in bed for the rest of the day. Clearly, a long-term-care home whose primary residents are the very elderly is no place for this young man.

Even when there are community supports available, it is still hard to move out of a long-term-care home, as a Toronto woman knows. She was diagnosed with MS in her mid-20s and able to manage on her own until she was about 45. In 2000, she developed a wound and had to be hospitalized. While there, she was advised by health care professionals that it would not be safe to continue to live on her own. She and her family began the process of finding a suitable place. In the meantime, she was sent from the acute care hospital to a facility for rehabilitation therapy. Frankly, this may have been a tactical mistake, since she was then considered to have adequate housing. She was passed over for attendant care apartments because there were people "in more desperate need" who didn't have housing. After three years, she finally agreed to move to a long-term-care home, where today, at the age of 50, she lives with residents who are very elderly and frail, and many have dementia.

These examples provide some background to our disappointment. When reading Bill 140, we found that the needs of younger people with MS and other diseases and disabilities are not addressed in the proposed legislation.

I'll now ask Deanna to review in more detail our concerns about the proposed legislation and to provide our recommendations for improving it.

**Ms. Groetzinger:** Thank you, John. Although only a minority of people younger than age 65 with MS require care in a long-term-care home, it is vital for their quality of life that their housing is appropriate for their age. Too often they are placed with much older individuals in settings designed for frail elderly people. This can result

in a significantly reduced quality of life, which can lead to depression and mental health problems.

In the view of the MS Society, the appropriate solution is to have available a continuum of appropriate housing and care. Most importantly, Ontarians who are disabled or chronically ill should have the supports they need to remain in their own homes. If, because of increased care needs, remaining at home is not possible, there should be a range of age-appropriate housing and care options.

This is not just an issue for people with MS and the MS Society. A 2006 study by the Canadian Institute for Health Information found that 20% of residents in continuing-care facilities in Ontario hospitals were younger than 65. The Canadian Healthcare Association reported in 2005 that in the Ontario facilities that provide complex continuing care, about 40% of residents are under 65 and the number is increasing. MS Society research found in 2000 there were 225 individuals with MS living in long-term-care homes, with care needs ranging from moderate to high.

Age-appropriate housing for young adults with disabilities is an issue of growing concern and is of particular significance in the case of MS, which is diagnosed most often between the ages of 15 and 40. People who develop MS must cope with the wide range of symptoms and disabling effects of the disease for the rest of their lives.

The MS Society strongly recommends that solutions for housing and care needs not be developed in isolation. Above all, the government of Ontario should adopt an overall approach of providing sufficient home supports to individuals who require health services or assistance with daily living. The philosophy of "home is best" should guide all subsequent decisions.

What this means is the development of resources for an effective, high-quality, equitable and accessible publicly funded home care system across Ontario for people with chronic long-term diseases like MS. Within this approach, needed mobility equipment and home adaptations should be funded, as should a coordinated system of social supports, including accessible transportation.

The MS Society was pleased to note that Monique Smith, parliamentary assistant to the Minister of Health and Long-Term Care, addressed part of this issue in her report *Commitment to Care: A Plan for Long-Term Care in Ontario*. Specifically, her report says, "There may be some pressure on CCACs to place some seniors prematurely into LTC facilities because of the availability of new beds and the shortage of funding for home care.... We suggest redirecting government funding into community alternatives and home care." And later in the report, "We recommend the ministry re-examine the new bed allocations with a view to stopping the building of those not yet in the ground and redirecting this funding savings to home care...."

The MS Society shares this concern, and has for some time, and has developed a report about age-appropriate long-term care called *Finding My Place*. While having an adequate supply of long-term-care beds is important, we

fear there is and will continue to be increased pressure on CCACs to solve their home care funding problems by persuading people to leave their homes and move into long-term-care facilities. This persuasion can be very direct. Imagine being told that you or your loved one can't have home care but your care problems can be solved easily by your moving to a long-term-care home, no matter if you are in your early 40s and your new roommate is in her 80s.

Therefore, the MS Society recommends:

—The government of Ontario proactively develop a sufficient mix of age-appropriate supportive housing, congregate care facilities and long-term-care homes across the provinces for Ontarians who can no longer live in their own homes.

—The government of Ontario develop clear policies regarding the placement of young adults with MS and other disabilities to ensure they receive age-appropriate care in age-appropriate settings.

—The government of Ontario ensure that age-appropriate long-term-care housing options are available across Ontario so people can stay in their home communities, close to family and friends.

—The government of Ontario include in the legislation a province-wide minimum staffing standard for long-term-care facilities to ensure there are sufficient staff to provide a minimum of 3.5 hours per day of nursing and personal care per resident.

—The government of Ontario ensure there are uniform provincial standards and funding assessment tools to be used by local health integration networks in planning home care and long-term care.

—Finally, while the creation of the Office of the Long-Term Care Homes Resident and Family Adviser appears to be useful and helpful, as is the strengthening of whistle-blower protections, an ombudsman for long-term care position should be created or the existing Ombudsman's responsibilities should be expanded to include long-term care.

On behalf of the MS Society, thank you for the opportunity to present today, and we look forward to your questions and comments.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We can divide them equally among the three parties. We'll start with Mrs. Witmer.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** Thank you so much for coming forward and letting the public know about this problem. I have seen it, unfortunately, in many of the long-term-care homes that I have visited where there are individuals with MS. They are unhappy in their placement because it's not the appropriate place for them to be. They're not complaining, but they're certainly pointing out some of the challenges that they're facing. I think it's absolutely imperative that this be a priority for any government of any stripe, to address this issue and to make sure that, with the increasing number of younger people who have MS or other disabilities, we develop a program whereby



there would be appropriate housing found for them. Obviously, if we can keep them in their homes and provide the appropriate support, we should do so.

I would say to you, don't give up. Let your voices be heard. This is a big issue. I found a mother with a daughter the same age as my daughter. I left that home and I thought, "That could be me." That daughter now has no home any more because the mother's home is in the long-term-care home. You know what? We just are not looking after some of these people in the way that we should be. This needs to be a priority for any government. So thank you so much, and don't give up.

Do you have copies of your report *Finding My Place*?

**Ms. Groetzinger:** Yes, I do. I can provide them.

**Mrs. Witmer:** I'd appreciate getting a copy. Thank you so much.

**Ms. Shelley Martel (Nickel Belt):** Thank you for your presentation today. I am pleased to note your recommendation about a minimum staffing standard of 3.5 hours and also the recommendation around an ombudsman, which are two details that I have particularly been pushing.

I want to address, though, more importantly, your concern about inappropriate placements. I agree with what Ms. Smith said in her report; therefore, I was very surprised when I saw a protocol that has been developed between the Ministry of Health and the Ministry of Community and Social Services that was signed in about June of this year. If you haven't seen it yet, I would strongly recommend you get a copy of it. We have copies of it that we could share. Essentially, the protocol sets out how clients with developmental disabilities will be admitted into long-term-care homes. So it doesn't specifically state folks with MS, but clients with developmental disabilities. What was most disturbing about the protocol is that it actively encourages developmental service community providers to urge their clients to move out of their community placements into long-term-care homes in order to make way for the clients who are coming out of the DS facilities like Huronia.

I encourage you to get a copy of this, because it runs absolutely contrary to what Ms. Smith had encouraged, which I agree with, in terms of what she encouraged. Maybe you can add your voice to the voices of many others in the development sector who are encouraging the government to abandon this particular protocol and these particular placement provisions.

I think you are absolutely right. I have an aunt who has had MS for well over 30 years and almost all of that has been in a hospital setting, chronic care, which is not appropriate, but there wasn't any other support in the community for her to go to. So we do, regardless of our political stripe, need to work together to find appropriate placements, both age appropriate and appropriate in terms of dealing with people's needs and disabilities etc. So thank you for your presentation today.

**Ms. Groetzinger:** Thank you. I don't think we were aware of that directive, so I'm happy to receive that information.

**Ms. Martel:** We will get it to you.

**The Vice-Chair:** Parliamentary assistant?

0920

**Ms. Monique M. Smith (Nipissing):** It's great to see you again. We have had a chance to discuss your report and some of your concerns. I'm glad to see that Mrs. Witmer has seen the light. For someone who represents a government that cut home care, it's nice to see that she's coming around to the notion that aging in place is incredibly important and that living in your own home, for those who are suffering from MS and other debilitating diseases, is incredibly important.

I just want to point out that in the legislation we have tried to incorporate some provisions that will address or begin to address some of the concerns, including in clause 7(1)(a) "an organized program of nursing services for the home to meet the assessed needs of the residents" so looking at each resident individually and trying to really meet their needs. Again, in subsection 9(1), we have a recreational program that hopefully will address the specific needs; in subsection 178(2), providing different types of programming; and in the bill of rights, paragraph 19, "...the right to have his or her lifestyle and choices respected." So a few provisions that hopefully will go some way.

We have, of course, discussed the problem of the numbers and trying to find age-appropriate housing to address in some communities a very small number of individuals who need a different type of housing. I know that aging in place is really your first choice. Certainly, in my report and elsewhere I have supported the need for home care and increased resources in the same. We continue to work on that; our government has made substantial investments in the home care sector and we continue to do that.

I just want to thank you again for coming today and raising your concerns and sharing your knowledge with us.

**Ms. Groetzinger:** You're welcome. We did note in the proposed legislation that there are attempts at accommodation for individual service needs. We would urge an amendment to the bill which actually does bring out age appropriateness as one of those. So that might be something that this committee might want to consider, that while the language is already there, this committee might want to consider strengthening that to address some of the concerns that we've raised today.

**The Vice-Chair:** Thank you very much for your presentation. There's no time left.

#### ONTARIO PUBLIC SERVICE EMPLOYEES UNION

**The Vice-Chair:** Next will be the Ontario Public Service Employees Union. Welcome. Before you start, please state your name for Hansard.

I recognize Mrs. Witmer. Mrs. Witmer, you have the floor.

**Mrs. Witmer:** Yes, thank you very much. I'd just like to correct the record. Ms. Smith had indicated that we cut home care. I think if you take a look at the record of the Ontario Progressive Conservative Party between 1995 and 2003, we made one of the largest investments in long-term care and community services. I would like to correct the record in that regard.

**The Vice-Chair:** Thank you, Mrs. Witmer. Now I guess we can start.

**Ms. Leah Casselman:** Good morning. My name is Leah Casselman. I'm the president of the Ontario Public Service Employees Union. I want to thank you for the opportunity to speak to the standing committee today. I would like to also point out that I have met Mr. Bavington in the back here; he is one of the folks who was unable to present to your committee. It's unfortunate, because he obviously has some very important issues to raise, as do, I'm sure, the other participants who are not able to present to your committee. It's unfortunate that you weren't able to find the time to hear from all of the citizens who are concerned about this piece of legislation.

OPSEU represents more than 115,000 workers; 30,000 of those are employed in our provincial health care system and included among them are 1,600 members who work in 19 long-term-care homes.

With me today is Debbie MacDonald, who chairs OPSEU's long-term-care sector. She is a clerk at the Sherwood Park Manor nursing home in Brockville. Before she took up that position, she was a health care aide. She's now a clerk, after being permanently injured on the job in 1998. She was attacked by a resident, pulling her right arm out of its socket, tearing her rotator cuff, shattering a disk in her neck and severing a nerve in her right arm. Debbie understands the risks that workers take on a day-to-day basis when it comes to the understaffing issue in homes.

Bill 140, quite frankly, is long overdue. It does achieve some of our shared goals for improvement in long-term care, including random inspections, official recognition of family councils and legislated limits on the use of physical and chemical restraints.

However, our expectations around the introduction of this bill were much higher. We all remember the Toronto Star and the Ottawa Citizen series on long-term care and the minister's tearful promise of a revolution in long-term care. Yet almost all of the new legislation is a formulation of modest policy changes that have existed for the past three years.

While much of the bill focuses on the rights of residents, we believe that these rights lack reasonable means of enforcement or staff to carry out the necessary care. Staffing levels are the primary indicator of quality service. Not only does the bill lack any minimum staffing requirements, it fails to address the impact of ownership on overall staffing. While we have numerous concerns around this bill, I'd like to spend our time on this critical issue.

**Staffing standards and ownership:** Prior to 1995, long-term-care homes were required to provide a minimum

average of 2.25 hours of care per day per resident. When it was eliminated by the Harris government, the opposition Liberals vowed to restore this minimum. The promise was not forgotten during the 2003 election. In a survey sent out by the Ontario Federation of Labour, Dalton McGuinty said, "Ontario Liberals are committed to reinstating the standards of care for nursing homes that were removed by the Harris government, including a minimum of 2.25 hours of nursing care daily." Shortly after being elected in 2003, Minister of Health George Smitherman led us to believe that action was coming soon, promising a "revolution."

In 2005, the standing committee on public accounts was led to believe again that the ministry was addressing this issue. The November 2005 report of the committee states, "Current work on staffing hours will establish a floor. With a flexible range, the ministry is moving towards being more definitive about staffing expectations."

Despite an expanding body of evidence that demonstrates how critical staffing levels are to good health outcomes in long-term care, despite repeated promises, staffing minimums remain noticeably absent from Bill 140.

Staffing standards need to go beyond 2.25 hours per day. Studies looking at staffing and health outcomes in long-term care indicate that government needs to do more than bring back the cancelled minimum of 2.25 hours per day; it needs a higher standard.

The most empirical study on this issue was conducted by the US Congress, of all places. An 800-page first phase of the study was published in the summer of 2000, reflecting a decade of work that establishes a clear and irrefutable link between low staffing levels and poor health outcomes in nursing homes, including avoidable hospitalizations, incidence of pressure sores and weight loss. The report concluded that minimum staffing levels reduce the likelihood of harm, while higher preferred minimums actually allow the homes to improve health outcomes. What a novel idea. Total staffing minimums just to avoid harm—just to avoid harm—are set by the report at 2.95 hours of care per day. To actually improve health outcomes, the report raises the bar to 3.45 hours per day of minimum care.

The US Congress report on staffing minimums has been very influential on governments: 36 US states have adopted minimum staffing levels for long-term care, and the District of Columbia also adopted standards in 2005. Many have increased their standard in recent years. Total staff hours per resident per day in 2004 averaged 3.6 in the US. The top 10% of US nursing homes average 4.55 hours per patient per day.

The staffing levels of US homes and those in other Canadian provinces continue to be well above Ontario's. In 2001, a PricewaterhouseCoopers study concluded that Ontario offered the lowest amount of total direct care hours among the sample jurisdictions it studied. At the time, Ontario provided 2.04 hours of care per resident per day. The 1995 and 2002 auditor's reports noted inaction



on such issues as the staffing mix and appropriate levels of funding. The latter also noted inaction in addressing the findings of the 2001 PricewaterhouseCoopers report.

If the government refused to be moved by Ontario's low ranking—as we've seen in the college sector—among many sample jurisdictions, it might have listened to the April 2005 coroner's jury's report following the deaths of two nursing home residents at North York's Casa Verde long-term-care home. In 2001, a 74-year-old resident with dementia beat to death two others with a metal bar. Among the 85 recommendations by the coroner's jury was one to set standards requiring long-term-care facilities to increase staffing levels to an average of no less than 3.06 hours of care per resident per day, based on the average case mix measure.

**0930**

Did Ontario listen? In 2005, the standing committee on public accounts wanted to know. They requested that the Ministry of Health report back on the 2004-05 staffing surveys of long-term-care homes in Ontario. They gave the ministry 120 days to report back. The results of those surveys are still not public, nor have we had an update on the original PricewaterhouseCoopers study.

In our research, we have seen average estimates ranging from 2.3 to 2.6 hours per day. Anecdotal evidence from our members would suggest that these numbers have been very optimistic. Our members are reporting very little change in existing staffing complements. At Sherwood Park Manor in Brockville, where Ms. MacDonald is from, we begin 2007 with fewer staff than we had in 2006, not more staff.

If there is money for new staffing in existing homes, where is it? According to the Ontario Association of Non-Profit Homes and Services for Seniors, of the \$740 million in new money over the past three years, only \$173 million went into operating budgets to support resident care in homes. Show me the money.

Data on the total number of long-term-care beds in the province would suggest that the bulk of new workers and money went into new beds, not existing ones. In just four years, from 2002 to 2006, Ontario went from 10th to fourth in the number of beds per 1,000 residents aged 75-plus. This would indicate that the policy direction has been towards quantity, not quality, of long-term care.

No matter whose estimates you choose, either continues to indicate that Ontario lags far behind other jurisdictions in staffing. According to the US Congress study, we are continuing to do harm to our residents.

We can only speculate on the reasons for the government's intransigence in following through with its promise regarding staffing minimums. Cost is likely to be only a partial factor, given that new staffing would likely offset the public cost of workplace injuries. Cost was less a factor during the election campaign when the present government promised to increase funding to long-term-care facilities by \$430 million annually.

So did the government bow to pressure from the for-profit sector? More likely to be a factor in abandoning

staffing minimums is the percentage of long-term-care homes provided on a for-profit basis. The Harris government dramatically shifted the ratio of for-profit and not-for-profit homes, and this trend has continued unabated by the Liberal government: 60% of Ontario's long-term-care beds are now in the for-profit sector, more than twice the ratio of the next-highest province. That's BC, where they license 30% of their long-term-care beds to the for-profit sector.

The largest cost to any long-term-care home, of course, is its staff. While in the past staffing costs could be reduced by lower wages and benefits, the competition for qualified staff makes it much more difficult for profit-seeking homes to make up their margins in that way. As recruitment and retention problems grow, it is likely that for-profits will migrate from lower wages to even fewer staff to provide sufficient return on investments, of course, because that would be their priority.

For-profit versus not-for-profit beds: A recent BC study published in the Canadian Medical Association Journal definitively shows that for-profits are already in an inferior position with regard to the provision of overall direct care staff. In that province, residents in for-profit homes received an average of 18% less direct care than those in the not-for-profit sector. For-profits averaged 2.8 hours of care per day, while those in the not-for-profit sector provided 3.43 hours of care per day. These statistics, of course, do not take into account the higher number of volunteer hours that not-for-profit and municipal homes attract.

Given irrefutable evidence that higher staff levels predict improved health outcomes, which I think we would all be interested in, we would have to logically conclude that lower staff levels in for-profit facilities would suggest worse health outcomes. Given the direct link between staffing levels and health outcomes, Ontario's rush to for-profit care was ill-advised and contrary to all existing evidence. While the government continues to lecture health care providers on the importance of evidence-based decision making, it appears to be ignoring all evidence regarding the importance of minimum staffing levels and on comparable health outcomes in for-profit homes.

OPSEU has two recommendations on staffing minimums and ownership.

(1) The bill should require government to set a regulation for minimum staffing levels. Ontario should implement a minimum requirement of 3.5 hours of care per resident per day average, based on the average case mix measure. This minimum should be reviewed every three years.

(2) The government should completely ban not-for-profit from selling their beds to for-profit providers. While the government highlights the need for balance, we believe that the system is presently unbalanced with 60% for-profit beds. The government must introduce a moratorium on the awarding of all new for-profit beds until an analysis can be completed on the comparable merits and costs of for-profit versus not-for-profit care in

Ontario. If the results are comparable to the BC and US studies, the government should permanently halt any new for-profit beds. All new long-term-care beds in the province of Ontario should be either not-for-profit or publicly provided.

Patty Rout, who chairs the OPSEU health care divisional council, will be making further comments on the contents of Bill 140 later on this morning. Meanwhile, we would like to be able to field any questions that you may have from our presentation. Thank you very much.

**The Vice-Chair:** Thank you very much. You used most of your time. You still have ten seconds left. I guess it's not enough for questions.

**Ms. Casselman:** Thank you. I'm sure Patty will be able to answer any questions you may have with her presentation.

### TORONTO HOMES FOR THE AGED

**The Vice-Chair:** Next will be Toronto Homes for the Aged. Welcome back to this committee.

**Mr. Joe Mihevc:** Good morning. Good to be here.

**The Vice-Chair:** It seems you have a big support with you. If you don't mind, can you state their names.

**Mr. Mihevc:** We're brought a phalanx, yes. I'm Joe Mihevc, city councillor, chair of Toronto's new community development and recreation committee. I'm joined by Sandra Pitters, who's our general manager of homes for the aged, Cheryl MacDonald, and Reg Paul, who are senior policy adviser and senior staff with homes for the aged, as well.

I'd like to first and foremost thank members of the standing committee on social policy for the opportunity to comment on and provide suggestions to improve Bill 140. My comments reflect the city's particular knowledge of Toronto's diverse communities, our responsibility for the well-being of residents, a strong culture of partnerships and collaborative models of care and the values of mutual respect and co-operation embodied in the City of Toronto Act.

Toronto, as you know, is Canada's largest city, but sixth-largest government, home to a diverse population of more than 2.6 million people with complex service needs. To paint a brief picture: of the total GTA population, Toronto has 68% of people who live below the poverty line, 73% of tenant households, 59% of seniors, and 66% of recent immigrants. Toronto Homes for the Aged understands this complexity and is a community leader in services for seniors, providing 10 homes for the aged that provide care to over 2,600 residents; dementia care and other specialized programs; and a range of community partnerships and support programs, including adult day programs, a supportive housing program and a homemaker and nursing services program and meal preparation for community-based Meals on Wheels programs, in partnership with community agencies.

Toronto Homes for the Aged has a history of working with the province, residents, families and community partners to identify solutions, resolve issues and work to

improve care. Our care and service systems are designed to respect the ethno-cultural background, culture, language, family traditions, community, sexual orientation, gender identity, spiritual beliefs and rights of each resident. Through additional city funding, Toronto Homes for the Aged has been able to design and implement creative programming to respond to our community's diverse needs. This would not be possible solely through the current per diem funded by the Ministry of Health and Long-Term Care.

### 0940

So on to Bill 140. Bill 140 is a welcome and much-needed piece of legislation, a critical component to strengthen and reform the long-term-care system. We support the introduction of new, consolidated legislation for all long-term-care homes in Ontario and support the overarching goal and fundamental principle of building a strong, safe long-term-care system and creating a home environment for residents.

Our submission recognizes the positive aspects of Bill 140, including much of the content regarding care planning and care provision, the zero-tolerance approach regarding abuse, the focus on residents and their families and the move to more community involvement in long-term-care homes. These are principles and processes fundamental to the philosophy of Toronto Homes for the Aged and are already in place.

But while we agree with the spirit of the legislation, we are concerned with its application in a significant number of key areas. Our submission—I think you have it here—identifies areas where we believe you have missed the mark, identifies a number of weaknesses and provides ideas on how we think the bill can be improved. As well, we have provided a detailed clause-by-clause analysis that includes recommendations for deletions or rewording or suggestions for additional comment where the gaps have been identified.

When the government released its Commitment to Care report, we were encouraged and supportive of the vision and direction. Commitment to Care recognized that there are some very good long-term-care homes in Ontario and also recognized the need for increased authority to control those long-term-care homes not committed to providing care in a way that supports the dignity, security, safety and comfort of residents. Commitment to Care was balanced and interconnected. It reflected on the strengths of the long-term-care system and recognized it as an important component of an overall health care system. It suggested to us that the future legislation would adopt principles of quality management and a multi-faceted approach to improve the system as a whole.

Overall, we are disappointed in Bill 140 as we do not see the spirit, vision and intent of Commitment to Care reflected. We do not see a focus on system improvement, but rather, a punitive approach to the entire long-term-care homes system that treats all homes as a single entity, somewhat suspect, that must be closely monitored and controlled. The bill is overly prescriptive and will result in the loss of opportunities for innovation, flexibility and



the achievement of best practice because the primary focus will be on the avoidance of compliance and enforcement penalties.

We also feel that the bill should codify permissiveness for long-term-care homes to adapt both individual and group care and service to respond to ethno-racial, cultural, linguistic, religious or community-of-interest traditions and values as long as the flexibility does not result in negative outcomes.

Research in other jurisdictions indicates that organizations that support innovation and encourage excellence through true quality management principles achieve better outcomes than punitive approaches and highly regulated environments. We believe that positive outcomes are achieved when organizations are committed to meeting community need, operate through a resident-centred approach, include residents, families and communities in planning and delivering care, and effectively use a true risk and quality management framework.

Bill 140 assumes that long-term-care homes operate in isolation from the rest of the health care system—a further point. There is no recognition of the relationship that needs to exist between long-term-care homes, hospitals, community care access centres, local health integration networks and other health care and community organizations in order to meet the goal of a truly integrated, responsive, client-centred system. The draft legislation misses the opportunity to build long-term-care homes into a broader, transformed health care system as a valued partner.

We find it worrisome that the draft legislation offers no commitment to fund long-term-care homes at the level needed to provide the right level of care, achieve the enhanced quality that residents deserve or support homes in meeting the expanded legislative requirements. Although the word “ensure” is used liberally throughout the bill in terms of the obligations on long-term-care homes, it is silent on the obligations of the provincial government to ensure adequate funding to provide high-quality care. As an order of government, municipalities have a mandatory obligation to operate long-term-care homes yet there is no obligation for the province to provide sustainable operating funding or funding for capital renewal. We are concerned that this sets long-term-care homes up for failure.

Lastly, long-term-care legislation must respect the governance and accountability mechanisms already present in the municipal sector and build on its strengths rather than introducing a one-size-fits-all approach for the municipal, charitable and for-profit sectors. The province should respect and work with the city of Toronto and other municipalities as an order of government and as a partner with its own mandate to plan, fund, implement and monitor services across the city to best meet the needs of our diverse citizens.

Our submission provides a list of 29 recommendations; I want to highlight a few in particular. The revised bill must:

(1) Reflect the spirit and intent of Commitment to Care;

(2) Respect municipalities as an order of government with their own governance structures and accountability mechanisms already in place, and develop and codify a collaborative or consensus approach for the municipal sector;

(3) Contain a sunset clause requiring a two- or five-year review of the legislation;

(4) Eliminate use of the word “ensure” throughout the bill, replacing it with phraseology something like “take every reasonable step to ensure”;

(5) reduce the prescriptiveness and rigidity of the bill, building the new Long-Term Care Homes Act into a true risk management and quality management framework, thus realizing a more vibrant long-term-care homes system with improved outcomes and enhanced creativity that cannot be achieved through a strict, punitive compliance, inspection and enforcement system;

(6) Provide reasonableness for directors, officers, physicians, managers and staff of long-term-care homes when they have carried out all of their work-related activities and responsibilities in good faith and with the honest and deliberate intent of meeting the ministry’s requirements and objectives for providing a home where residents may live in dignity, security, safety and comfort;

(7) Provide an onus on the Ministry of Health and Long-Term Care to provide sufficient funding for long-term-care homes—both operating and capital dollars—to provide high-quality care and meet their obligations. This is particularly important for municipal long-term-care homes, which have a mandatory obligation to operate; and

(8) Revise the bill of rights so that it is clear that one individual cannot impose his or her will in a way that violates the rights of another individual or a group of individuals.

To conclude, Bill 140 provides a unique opportunity for the province of Ontario to make lasting improvements to the long-term-care health system, encourage community partnerships, and encourage creative and innovative approaches. This submission lays out recommendations for change. The Toronto Homes for the Aged is prepared to work with the province of Ontario to make the necessary revisions before the bill is passed into law.

I just want to conclude by thanking the standing committee on social policy for providing this opportunity for input.

**The Vice-Chair:** Thank you very much for your presentation. I have two minutes left. We can divide them for quick questions. Ms. Martel.

**0950**

**Ms. Martel:** Thank you for your participation today and for the work that was done, especially the drafting of the amendments, which will be very helpful.

I’m just looking on page 17 of the brief, where you said you were disappointed that “the concept articulated in Commitment to Care related to the creation of an ombudsman office, was not realized in Bill 140.” I wonder if you can elaborate on that for us, please.

**Mr. Mihevc:** I think Sandra Pitters is in a better position to answer that question.

**Ms. Sandra Pitters:** Thank you, Councillor. We do believe that there is a valuable role for a strong advocacy concept for residents who reside in Ontario's long-term-care homes. We don't believe that Bill 140 explicitly provides that authority and that opportunity for residents, families and individuals involved with community and long-term-care homes to go to someone to assist with self-advocacy, individual advocacy or systemic advocacy changes that might be required as this bill is being introduced.

**Ms. Smith:** I just want to follow up on those comments. The role that an ombudsman usually plays is one of investigation at the end of a situation. What you're promoting is more of an advocacy role, which is more in line with what we know that the city of Toronto has and what we were looking at in the Office of the Long-Term Care Homes Resident and Family Adviser. How would you distinguish or how would you create that role without—or do you envision that role also including the investigative and reporting function that an ombudsman normally has?

Before you answer that question, I just want to say to the councillor and others that you are very fortunate to have Sandra Pitters on your team.

**Ms. Pitters:** I don't know how to answer that after a compliment in public. I appreciate that.

We really did focus on the advocacy component, although we understand that in the advocacy role the individuals associated with the office might be doing some investigative processes, but it really would be in an advocacy spirit to assist the resident, the family, to resolve the issue in the way that meets their needs.

**Mrs. Witmer:** Thank you very much for a great presentation and recommendations. You've indicated that the bill is very prescriptive, very punitive and, unfortunately, that there's no funding provided. Then, in the amendments, you talk about the need to provide reasonableness for directors and staff etc., meaning what precisely?

**Mr. Mihevc:** I'll let Sandra answer that as well. But as I understand the draft legislation, it very well may mean, for example, that city councillors, who have an overall policy and leadership function, would be liable for particular mishaps and not meeting standards of care. We think that that piece within the legislation needs to be looked at more clearly and that the principle of reasonableness needs to be incorporated.

**The Vice-Chair:** Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE  
EMPLOYEES UNION,  
HEALTH CARE DIVISIONAL COUNCIL

**The Vice-Chair:** The next presentation will be by the Ontario Public Service Employees Union health council. Good morning. You can start whenever you're ready.

**Ms. Patty Rout:** I am Patty Rout. I am chair of the OPSEU health care divisional council. I represent 30,000 members from the various health care sectors, such as long-term care, hospital professionals, paramedics, mental health employees, community health professionals and hospital support workers. Earlier you heard from Leah Casselman and—

**The Vice-Chair:** Can you introduce the person beside you?

**Ms. Rout:** Sorry. It's Debbie MacDonald. Earlier you heard from Leah Casselman and you didn't have an opportunity to talk to Debbie or ask questions, so hopefully we'll have time for that after I'm finished. Leah and Debbie both feel the absolute need for staffing minimums and a moratorium on new for-profit beds.

I'd like to share the views of our members with respect to accountability and transparency in the long-term-care sector, as well as whistle-blowing, inspections and the rules around the revoking of licences as outlined in this act.

**Accountability:** OPSEU shares the government's interest in accountability in the long-term-care sector. But we think accountability is a two-way street. In this bill, almost all the accountability falls on the individual homes and very little of it falls on the government as the funding body, the inspector, the regulator. There is a huge difference between for-profit homes and not-for-profit. The differences should be reflected in the accountability measures. Ontario's non-profit and public facilities have approved beds, which means they can operate as approved by the provincial government. For-profits have licensed beds, which have value on open markets. I believe it would be very scary for a senior to know that they're a commodity which is bought and sold on the market itself. The for-profits' mission is to make money.

**Fines:** A board member on a not-for-profit home often serves in an unpaid capacity, and their primary goal is to run the facility as a public service. The board members of a for-profit home are paid and have a different primary goal: to maximize profit to shareholders. Yet Bill 140 treats the two in the same way when it comes to individual fines for non-compliance. If faced with the first-offence fine of \$25,000 or 12 months in jail, people may be less likely to volunteer for the non-profit boards. Fines should also be based on the size of the organization to be equitable. A \$50,000 fine may be a slap on the wrist for Extendicare or CPL, but for a small non-profit home, it's huge. Fines should be based on the number of beds held by the organization or company, not just on the individual home.

**Transparency:** The Web is where many working families go for their information these days. Given the current trend to make health care decision-making more transparent, we believe the reporting of quality indicators and standard violations should be available on an accessible website. The present website is not easy to find, it's not user-friendly to families, it's not easy to navigate, and it lacks the kind of reasonable detail that would allow families the ability to make an informed choice.



Unmet standards are reflected as a vague category on the website now. They give no detail on the level of the seriousness of the unmet standard. The average person reads that there is one dietary unmet standard. That really tells them nothing.

Also, the site only maintains very recent information. There is nothing on the Casa Verde page, for example, that would indicate the headline-making events of 2001 that took place there. You would think that families would want to know that two residents had been beaten to death at the home five years ago.

Staffing levels are a critical indicator. The province should stop hiding the results of its 2004-05 survey and place staffing levels at each home on the long-term-care website. This would not only provide families with the information that they would need, but it would pressure homes with poor staffing levels to upgrade closer to the provincial standard. Detailed results of the inspections should be made available on the website and key indicators should be made public, including the average staffing per hour per resident.

Whistle-blowing legislation: While whistle-blowing legislation is welcome, the new protection for workers is barely more than the existing status quo. While it is possible to grieve a dismissal or go to the Ontario Labour Relations Board, the likelihood of a worker wishing to endure this process while they're suspended without pay is a major barrier to stepping forward. This is true particularly amongst lower-paid workers in the sector and those who are not organized. We believe there should be a strong deterrent to employers wishing to dismiss or suspend staff for whistle-blowing.

**1000**

I can draw from an example during SARS, Justice Campbell's report, where he allowed people to come forward knowing they would not lose their jobs. We're talking about the same sort of thing here. The legislation needs to spell out the penalties to homes which punish whistle-blowers. We also believe there should be a provincial long-term-care ombudsperson able to intervene in such circumstances as soon as possible.

Inspections: OPSEU supports placing surprise inspections in the legislation. We support immediate investigations of complaints. We also support the rewarding of homes with exemplary records from the need for annual inspections, much the same as in the hospital sectors. Inspectors should be mandated to speak to staff, residents and families at homes, not just the administration. They should also have the mandate to check all service delivery aspects of the home, including contracted-out services.

We do agree that the focus and necessary monitoring resources should be placed on the consistent violator. We would recommend one further trigger for inspection: that any serious violation in one home of a chain should prompt immediate inspection of others in the same chain. This would pressure large corporate chains to make sure all their homes are compliant.

Screening of directors and corporate officers: While background screening will now be required for all new

staff at the homes, we cannot understand why there is not a similar screening required of new directors and corporate officers in the long-term-care system. Given past incidents such as Ontario's Royal Crest chain scandal, the government has yet to learn its lessons as to where the real problems lie. Background police screening should be extended to new directors and corporate officers who operate long-term-care facilities.

System changes—government's obligation to funding: Bill 140 places much emphasis on the rights of residents. It should also place equal emphasis on the obligations of government to adequately fund the services it asks homes to provide. Without a commitment to funding the change required under the act, we believe the situation for residents could actually worsen. Administrative requirements have been vastly increased by this act. Bedside resources cannot be diverted for such purposes. The act should specify funding levels that would adequately provide for both the administrative requirement and sufficient bedside care.

Regulations: We cannot understand why no public involvement or notice is required for the new regulations in the long-term-care sector. Certainly Bill 36 had its consultation process, and we would hope that the long-term-care act would specify notice periods and public input on the introduction of new regulations.

Revocation: Under the act, an interim manager can be appointed to run the home upon the loss of their licence or the revoking of a license. Under paragraph 155(5)1, the termination of an employee can take place during this period of time in which the employee's terms of severance are determined under the Employment Standards Act. In cases where the employee's termination takes place in the context of our collective agreements, the provisions that are in the collective agreements should clearly take precedence. Collective agreements should take precedence in all interactions with interim managers and unionized employees, and that would include severance.

Under the act, terms and conditions of employment or provisions of a collective agreement agreed to by the interim manager apply only with respect to the period of time during which the interim manager occupies and operates the home. If changes are negotiated to the collective agreement between the interim manager and the employee representative, these changes should be carried on to the successor employer. Any changes to the collective agreement negotiated between the interim manager and the employee representative should be treated as successor rights when the province restores or sells the facility to the previous or new employer.

Thank you for giving me the opportunity. Deb and I are both here to answer any questions.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left for quick questions. The parliamentary assistant.

**Ms. Smith:** I was interested in your comments about the level of care that we're providing. I don't know if you saw the Toronto Star today, but we have released the number. It's 2.86, from our most recent staffing assess-

ment of hours of personal and nursing care. We've also hired over 4,900 new front-line workers in the last two and a half years, including 1,100 nursing staff, and we've invested over \$740 million in increased funding, or 34%, into the long-term-care sector. So I am a little bit surprised to hear that you're not seeing that on the front lines. I do recognize that the CMI affects the home and the level of care that's required in the home, but I was surprised to hear that you're not seeing any of those investments coming through.

We've also invested a great deal of funding in lifts and other equipment in our long-term-care homes to attempt to assist our staff in order to ensure that there is a safer work environment for our staff.

I just wanted to set the record straight on a couple of the points that you made and to assure you that we are committed to increasing the level of care in our homes and ensuring that our residents have the best quality of life that they can. Thanks for your presentation.

**Mr. John Yakubski (Renfrew-Nipissing-Pembroke):** Thank you very much for joining us today. I appreciate your presentation. I'm not surprised that the government would have a press release out today. That's just the way it works, because they're not getting all that good a press from the regular press on this bill and this issue.

Would it be fair to say that regardless of the task you expect anybody to complete, if they're ill-equipped to do it, success is unlikely? What we seem to hear repeatedly from people who are charged with delivering long-term care in this province is that there are an awful lot of demands placed on them with regard to the care that is expected and the policing of that care, if you want to call it that, but the government simply hasn't backed it up with the resources that are necessary. I wonder how we can possibly succeed in improving the level of care in our long-term-care homes if the government is not prepared to back up that tough talk with some real funding that will deliver that.

**Ms. Debbie MacDonald:** You can't. You will not succeed. The CMI is the most flawed way of funding ever for nursing homes. We went down only 1.7% in my nursing home, which doesn't sound like a lot. That means 10 hours of direct personal care to a resident per day. Ten hours of care means one less staff feeding people breakfast. One staff feeds four to eight people. One staff gets up eight to 10 residents. Now the rest of the staff will have larger numbers, so now they will be feeding 12 people, getting up 15 people; one less person to toilet, so they're going to get toileted less. It means one less person to maybe comb hair, to do all the little, minor things that we just take for granted. There is no one there to do it.

Ten hours means one less person on an evening shift to put people to bed, to help bathe them, to help rub their skin with lotion which will prevent bedsores. Ten hours doesn't seem like much. It's huge in a nursing home in direct care; 1.7 is nothing.

**Ms. Martel:** Thank you for your presentation today. Let me just follow up with this. My question would be,

when you have staff doing the extra work, you increase your likelihood of someone getting hurt, usually a staff person. You didn't tell the committee, or you didn't have the chance to tell the committee because we didn't get to questions, about how you got hurt. Were you working alone? Is that what happened? Were you trying to lift someone? What was the nature of the incident?

**Ms. MacDonald:** Yes, I was working alone. I was responsible to get up 15 residents that day. I went in to the first resident and took him into the bathroom. He was an Alzheimer's patient, twice my weight, six inches taller. He panicked, or for whatever reason, and he latched onto me very hard. He pulled my arm out of the socket. At that time, I thought I was going to pass out or be ill, but I couldn't, because I could not let this resident fall; that was my first thought. I started to scream for help from another staff member. Unfortunately, it took 10 minutes before someone heard me and could come. In that time, a disc was shattered in my neck, my rotor cuff was torn, a nerve was literally severed in my in my arm, and nerves from where the disc shattered are permanently pinched in my neck. I will never have full use of my arm and my neck again, or range of motion. I have been an employee of this nursing home for 30 years and now I am a clerk. I don't get to do the job that I absolutely love any more because I don't have full use of my body any more. So in 10 minutes I lost everything.

**The Vice-Chair:** Thank you very much for your presentation. There is no time left.

1010

#### DENISE BEDARD

**The Vice-Chair:** The next presentation will be by Denise Bedard. Welcome, Denise. You can start whenever you are ready.

**Ms. Denise Bedard:** Good morning, everyone. Before I get started, I just want to say this is a wonderful honour and privilege to be here today. My name is Denise Bedard. I am the administrator for Scarborough Leisureworld and have been working in long-term care for almost 30 years. I want to thank you for the opportunity to present to this important committee today on behalf of all the residents in long-term-care homes across Ontario.

There is nothing more invigorating in life than being set free and being able to have a voice. As the administrator of one of the largest long-term-care homes in Ontario, I am proud to be here as a voice for my residents.

The growing demands on an already overburdened and inadequately trained long-term-care service will soar into the future. According to a 2005 Statistics Canada report, in 2001, seniors aged 65 and over accounted for 13% of the nation's population. Projections are that this number will reach 15% by the year 2011. The numbers of those 80 and over increased at the fastest pace and are expected to be an additional 43% from 2001 to over 1.3 million by 2011. This explosive growth in our aging



population will continue to make ever-increasing demands on long-term-care services in Ontario.

The lack of progression in long-term care to a person-centred culture by health care professionals has created a tremendous challenge for the health care field. Psycho-social, spiritual and geriatric therapies simply are not routinely taught to health care professionals. Barriers to the implementation of this culture include systemic, education, funding, and participation by family, staff, residents and the community at large. A major barrier is societal acceptance and awareness of aging and the aged, which are characterized by desensitization and stigma.

Amid the overwhelming level of need in the nursing home, it is easy to forget the enormous challenges inherent in the job of caring for our residents. Our present medical model of care pulls for efficiency and does not convey to the staff that personhood or even psychosocial care is part of one's job. In fact, staff may face explicit conflicts, such as complaints from supervisors and peers, if they try to focus on residents' emotions and psychosocial needs in the face of demands for efficiency.

Within this context, deficits in skill and motivation contribute further to the challenges facing caregivers. Lacking basic emotion-related skills such as listening actively and recognizing emotions in the elderly, the task of providing care may become overly daunting. As a result, recruitment and retention now become a huge issue within long-term care.

A recent report provided by the American Health Care Association in 1997 estimated a turnover rate as high as 97% among caregivers in health care. Only with extensive support to improve education and develop psychosocial skills to meet the enormous challenges of maintaining relationships can caregivers be expected to carry out the emotional work that is the hallmark of their job. We first must care for and re-educate the caregiver to be sensitive and to develop meaningful relationships with the residents. What most of us fear about going into the nursing home is that we have to leave who we are at the door.

Most often, residents and their families have been left out of the change process. For example, educational and informational programs have been run for staff but far less often for residents and their families. Since the care provided to the residents represents a direct interaction with them, and both a direct and indirect interaction with families, it seems necessary to engage residents and their families in any change process. Part of this has been addressed by the establishment of resident and family councils, which represent a positive step toward their participation and interaction.

Several key areas of this legislation need to be addressed very carefully as to their impact on the residents and their quality of life. Allow me to reflect on one example: the impact of the Smoke-Free Ontario Act and its implications on the life of our seniors in long-term-care homes. The Minister of Health Promotion passed this legislation in June 2006 with a view to protecting the health of workers. Unfortunately, he did

not take into consideration, nor did he consult with, residents as to the effect on them and the risk it created for them. With winter upon us, my residents, some of whom are palliative care, must go outside into harsh and dangerous weather conditions to smoke now that the minister has shut down their smoking rooms. With 55 smoking residents in this home, you can see the enormity of this problem. The SFOA is in direct contradiction to the residents' bill of rights issued by the Minister of Health, which requires that we provide care and protection to and address the needs of our residents. These contradictions in legislation make it impossible for us to keep our residents safe and secure without violating one piece of legislation or another. As an example, just this past week a resident went outside in the harsh weather to have a cigarette, slipped and fell, and suffered physical injuries and hypothermia from exposure to the weather. The government has inadvertently put the weakest and least able to defend themselves in harm's way while attempting to protect others.

Another area of concern with this legislation is the government's expectation that this bill will adequately address abuse. Addressing issues of abuse will not be accomplished if arbitrators retain the right to allow staff who have been found to have abused a resident to return to work. Staff are not going to come forward and report abusers if they know that it is likely that the person they are reporting will get their job back. There should be a supported policy of zero tolerance in issues related to resident abuse, and in proven cases of abuse there should be no opportunity for abusers to re-enter work in long-term care. This legislation needs to be amended to add a section to address this critical issue to protect both residents and other caring staff members.

Also, there is the issue of increased monitoring and paperwork from the Ministry of Health, all of which takes valuable time away from the quality of care of our residents. I would ask that the committee carefully review the level of reports and other paperwork required by the ministry with a view to limiting it to what is pertinent and critical. There is no benefit to the quality of life and care for our residents if our staff are tied to producing paperwork for the ministry which at the end of the day provides little or no benefit to their charges. With no additional funding to hire staff to address the ever-increasing paperwork load, the number of hours committed to actual delivery of care to residents diminishes at a time when it should be increasing.

Another critical area that must be addressed is the development and implementation of electronic patient records. When a resident suffers from an illness and is sent to the hospital, quite often there is a delay in receiving, or incomplete record of, that resident's health history. With the use of electronic patient records, care can be provided in an efficient and effective way. Electronic patient records would provide the hospital with timely and accurate information, which would reduce the wait for a paper record to arrive and eliminate the need for unnecessary medical tests or errors in prescription drug records.

Let me reiterate the most important element of my presentation to you here today, and that is the fundamental requirement that all health care workers be educated in the psychosocial skills required to nurture the physical and emotional well-being of those they care for. The time has come for Ontario to lead the way in long-term and specialized care by requiring all health care workers to be educated in psychosocial training. The reason I call it long-term and specialized care is because we are no longer caring for just the elderly in our society but for those of all ages and varied health challenges.

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Best practice can only be established when those responsible for providing health and therapeutic programs take into account the perspective of the resident and refute assumptions that impair their ability to participate in decisions and care. The very essence of long-term and specialized care is currently not found in this legislation, and that is the imperative of psychosocial skills needed, because with that common element, everything else will grow.

Thank you for allowing me to share my perspective with you. I look forward to addressing any questions or comments you may have for me.

**The Vice-Chair:** Thank you, Denise, for your presentation. We have three minutes left. We can have a quick question from each party.

**Mrs. Witmer:** Thank you very much, Denise, for your presentation. I do appreciate the emphasis that you've put on the need to focus on the psychosocial training. I do believe and would agree with you that that's extremely important if we're to provide the support that is required.

You raise an interesting point about smoking. I've never been a smoker, but I do appreciate that these people obviously do smoke. I guess if you could change and call yourself a government casino, maybe then you'd be able to do so.

Anyway, you've indicated here that retention is a big issue. What can be done in order to make sure that you have the best-qualified staff possible, very simply?

**Ms. Bedard:** Well, I think it boils down to the time factor. With how much care we have to do, our orientation sessions—a lot of PSW workers can't read and write. Being able to provide to them the tools they need before they go into the job would probably help, because it would help them understand better what their role as a caregiver is as well. What's happening too often is the worker gets in, and because of the mass job routines that they have to do, it becomes tunnel vision and you forget about what is actually needed for the resident.

**Mrs. Witmer:** Thank you so much.

**Ms. Martel:** Thank you for your presentation here this morning. As the administrator of the home, you would have a very clear sense of your costs. I'm interested in whether you've done an analysis of what the increased burden might be to you in the home to deal with the requirements that the government is setting out.

**Ms. Bedard:** I'm sorry. Can you say that again?

**Ms. Martel:** Do you have a sense of how much it might cost you, either in terms of having to hire another staff person full-time or part-time, to deal with the requirements that the government is setting out in this legislation?

**Ms. Bedard:** I think what needs to happen with those psychosocial skills is that whole transformation piece of somebody or a team training the trainers to be able to go in and actually stay there for the time being so that the sustainability piece stays in place. What happens with a lot of great initiatives that take place is that usually the administrator or the DOC are the individuals who are trained, but with the paperwork and the time allotted for everything else, we're not able to sustain that. So having a train-the-trainer team of qualified individuals who are able to teach those psychosocial skills and to sustain that over a period of time—it would be phenomenal to have that.

**The Vice-Chair:** Thank you, Ms. Martel. Parliamentary assistant?

**Ms. Smith:** Thank you. We certainly do appreciate you coming in, Denise, and providing us with your insight. I appreciated as well the fact that you emphasized the retention and recruitment, because they certainly are issues in long-term care and they're ones that I've been talking about since I started my reviews.

I did want to point out to you that in the legislation under "Training," we have made certain requirements of staff, including that direct care staff receive training on abuse recognition and prevention; caring for persons with dementia—which I think addresses some of your concerns; behaviour management; how to minimize the restraining of residents and, where restraining is necessary, doing it in accordance with the act and the regs; palliative care, which you mentioned as well; and other areas provided for in the regulations. We're giving ourselves the ability in regulation to add to that list, but we certainly believe that training in those particular areas is incredibly important for all of our direct staff in long-term care.

I appreciate what you said today. I think some of what you were calling for is reflected in the legislation, and we're going to continue to work to ensure that your concerns are addressed. Thanks so much.

**Ms. Bedard:** Thank you.

**The Vice-Chair:** Thank you very much for your presentation.

#### ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

**The Vice-Chair:** We'll move now to the next presentation, which will be by the Ontario Association of Non-Profit Homes and Services for Seniors.

**The Acting Chair (Mr. Mario G. Racco):** Please start any time you're ready.

**Ms. Gail Carlin:** Thank you, Chair. We appreciate the opportunity to be here this morning. My name is Gail Carlin. I am the chair of the Ontario Association of Non-



Profit Homes and Services for Seniors, OANHSS, and I'm also the director of senior services with the region of Waterloo, which operates a 265-bed long-term-care home. With me today is Donna Rubin, our chief executive officer.

OANHSS is the provincial association representing not-for-profit providers of long-term-care services and housing for seniors. Members include municipal and charitable long-term-care homes, non-profit nursing homes, seniors' housing projects and community service agencies.

This is an important time for our members. New long-term-care home legislation will influence our sector and affect the lives of residents in long-term care for decades to come. It is so critical that we get it right.

OANHSS members support the intent of the bill to build a strong, accountable and resident-centred long-term-care system. However, we are very concerned that it falls far short of this goal. We believe the proposed legislation is seriously flawed and significant changes are needed if it is to have a positive effect on the lives of our residents both now and in the future.

Given the limited time available to us this morning, I will not detail the recommendations and amendments in our submission. Instead, I will address the concerns we have in a thematic way, starting with the lack of support for not-for-profits.

The McGuinty Liberals, in opposition and now in government, have consistently been very vocal in their support for not-for-profit health care delivery. We were pleased when the government put words into action by clearly establishing a preference for public health care and the not-for-profit sector in legislation such as the commitment to medicare act and the LHIN legislation. What has surprised and dismayed us is not only the absence of an equivalent preference in Bill 140, but also that it will have serious implications for the viability of the not-for-profit long-term-care sector.

This should be an alarm bell for the public and the government. The not-for-profit sector has delivered valued-added services for over a century. And, in a sector that is seriously underfunded, it is worth noting that all the public funding not-for-profits receive stays within the organization and, on top of that, the sector contributes millions more in added funding through charitable donations and municipal transfers. This figure was well over \$130 million in 2005. There is also growing evidence that not-for-profit delivery of long-term care results in more staffing and improved care outcomes for residents.

The bill requires the government to consider the balance between not-for-profit and for-profit delivery of long-term care when issuing licences. Despite the fact that a similar provision exists in the current legislation, there has been an increasing imbalance in the system, resulting in less choice for seniors and their families. A decade ago, approximately half of all long-term-care beds were operated on a not-for-profit basis. Today, our sector only accounts for about 48% of the total. We are

deeply concerned that we can find no provisions in this bill that obligate the government to reverse this trend.

OANHSS is calling on government to include in the preamble a strong and explicit statement that it is "committed to promoting and supporting not-for-profit delivery of long-term care in Ontario." In addition, we want a governing principle in the licensing section that commits the government to supporting not-for-profit ownership of long-term-care homes.

The second theme I want to pursue is the impact Bill 140 will have on resident care.

Bill 140 proposes a significant increase in regulation. While our association supports measures to enhance standards and ensure full accountability, this legislation is so excessively onerous that homes will be forced to shift already scarce resources to meeting new administrative demands. Staff will be forced to spend more of their time on compliance and documentation, and that will mean they have even less time available for direct care and services.

Long-term-care homes are already challenged by over a decade of inadequate funding. This additional burden of red tape will exacerbate those challenges. We are very concerned that the focus in the bill on prescriptive micromanagement is misplaced and could actually result in a lower standard of care in long-term-care homes.

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At a minimum, the province must analyze what added financial burden will be placed on homes as a result of these new regulatory demands and increase operating funding by that amount. Establishing new requirements and standards without providing the means to achieve them is only a prescription for failure.

A very clear example is the call for care standards being made by many at these hearings. We support this direction, but only if it is fully funded for all homes in Ontario. Ontario already falls far short of the level of care actually needed by Ontario long-term-care residents. Codifying a care standard can only improve the system if we have the financial resources to achieve it.

The provision related to secure units provides another example of imposing a financial burden. Secure units provide residents with significant dementias and behaviours with a safe environment and attention to their needs. Including these units as restraints will require adherence to extensive monitoring and reporting requirements. The workload implications are very significant. For example, meeting the documentation requirements for a 30-bed special care unit is projected to require at least one full-time nursing position with minimal commensurate benefit to the resident.

Another example is training and orientation. While we agree on the importance of homes having knowledgeable and well-educated staff and volunteers, the level of expectation outlined in Bill 140 is unreasonable and will impose a continuous administrative burden and cost on homes. It goes well beyond simply identifying requirements and delves into the specifics of exactly how orientation and training is to be conducted.

Bill 140 utilizes a highly detailed and prescriptive regulatory framework. We are concerned that it will seriously stifle innovation and flexibility in the sector and result in a reduction in the level of care and quality of life for our long-term-care residents.

The third theme I will speak to relates to governance. Our sector relies on community leaders who are willing to give freely of their time as volunteers to serve on boards of our operating organizations. They are not compensated for their time or expertise.

Bill 140 will impose higher obligations and harsher offence provisions on the directors of long-term-care homes than any other sector in health care, including hospitals. The proposed legislation could result in directors being subject to fines up to \$25,000 and imprisonment for any breaches of the act by anyone in the home. This will make it very difficult for the not-for-profit sector to maintain its current directors and attract new ones, especially since penalty provisions are not covered by standard directors and officers insurance in Canada.

The final theme relates to licensing concerns. The licensing provisions in the bill threaten to erode the financial strength of the not-for-profit sector by increasing the cost of borrowing and complicating refinancings. Specifically, the fixed terms for licence renewals puts constraints on the licence that will affect its collateral value. It is critical for financing and asset protection that the collateral value be maximized. All indications from the lending community are that fixed terms for licensing tied to structural compliance without a funded capital renewal program will increase the cost of long-term-care financing for our homes.

Furthermore, Bill 140 includes a provision whereby the licences held by not-for-profit homes may only be sold or transferred to another not-for-profit. This may appear to be protecting the not-for-profit sector, but in fact it will disadvantage us through increased risks and costs. It is like saying you can sell your home, but only to people whose names begin with the letters X, Y and Z.

Putting added restrictions on licences over and above those already resulting from fixed licence terms further reduces the financial viability of not-for-profit homes. There is no such restriction on for-profit homes, giving them an advantage in terms of the market value of their licences and therefore their ability to finance at more competitive rates. This is a major concern with Bill 140 for our members and we have recommended that the restriction on sales be removed.

On the municipal side, while we support the mandatory requirement for municipalities to operate homes, the approval approach deprives municipal homes of any of the collateral value that would attach to licences. This puts them at a distinct disadvantage with respect to recouping any equity the municipality has invested in the home. We are recommending a new provision that will enable municipal homes to protect their investment without applying the licensing approach.

In concluding my remarks, I want to make very clear that while we support new legislation for long-term-care

homes, we are on the wrong track with Bill 140. As stated, we are very concerned with the provisions in the bill that disadvantage not-for-profits and with the many sections that are so prescriptive and excessively onerous, with no significant improvements to care.

Together, government, providers, consumers and their families must work in partnership to create legislation that enables and encourages innovation, flexibility and excellence in the delivery of long-term care in Ontario.

**The Acting Chair:** Thank you for your presentation. We have three minutes left, one minute each. Ms. Martel, you're first.

**Ms. Martel:** Thank you for your presentation here this morning. Earlier, the parliamentary assistant said that the government put \$700 million into long-term care. Can you tell me how much of that has actually gone to the residents to enhance their care directly?

**Ms. Donna Rubin:** In the first budget year, we would suggest that of the \$191 million, approximately \$96 million went; out of the \$264 million in the second budget, \$48 million; and in the third budget, of \$155 million, their own letter says that \$29 million is going directly to the per diem for a \$1.07 increase.

**Ms. Martel:** So despite what the government has to say, in fact, most of that money, or a good portion of it, didn't go to directly enhance resident care at all.

**Ms. Rubin:** Not from our perspective.

**Ms. Martel:** What's the shortfall, in your estimation, right now between what the government promised and where they are at?

**Ms. Rubin:** We're saying at least \$300 million to get us to a level that they promised back in 2003, and that was to move the sector, in our view, to about 2.75 hours of care.

**Ms. Martel:** And what about the shortfall in individual funding, the \$6,000 that was promised per resident?

**Ms. Rubin:** We're only a third of the way there.

**Ms. Smith:** You talked about the funding that's been received. In your 2004 annual report, you talked about the financial gain to your specific side of the sector—OANHSS—and your members receiving an additional \$110 million that saw per diem increases on average of \$5.50 a day for OANHSS members. How does that jibe with the numbers that you just gave to Ms. Martel?

**Ms. Rubin:** There was an equalization adjustment to provide not-for-profit members and other members that didn't have a certain funding supplement with added funding. But to be honest with you, that was still early days and we were under the impression that it was \$110 million. Figures now show it was \$96 million.

**Ms. Smith:** So that was \$96 million in addition to your side of the sector that the rest of the sector didn't receive?

**Ms. Rubin:** No, I'm sorry. I should clarify. When the minister contacted us early on, we felt that there was a full \$191 million, then there were reports that it was \$110 million, and then it became clear that it was \$96 million. So as months go by, you get a better picture of what the



full picture is. Having said that, you did invest \$191 million in long-term care.

**Ms. Smith:** In fact, we've invested \$740 million in long-term care in the last two years.

**Ms. Rubin:** Yes, it's a matter—all we're talking about is, does it go to direct care?

**The Acting Chair:** Thank you.

*Interjection.*

**Ms. Rubin:** Yes. We didn't include the new homes because if you're a person in a long-term-care home, it doesn't affect your level of care.

**Ms. Smith:** But that money—

**The Acting Chair:** Thank you. Mrs. Witmer?

**Mrs. Witmer:** Thank you for a great presentation. I think you've done a great analysis of the bill. We appreciate your input.

I'm a little interested. You indicated that the bill takes a very punitive approach. I'd like to ask you, what suggestions would you have to make the act more balanced between this carrot-and-stick approach?

**Ms. Carlin:** We would like to see a balance with incentives. We have suggestions for a number of types of incentives. It may include things like less frequent Ministry of Health inspections. It may include preferential treatment for homes that go beyond the standards for new programming; funds that become available for research grants that are available. There are a number of ways in terms of public recognition that the government can indicate that homes are exceeding the standards.

**Mrs. Witmer:** Thank you very much, Gail.

**The Acting Chair:** Thank you very much for your presentation.

#### ALZHEIMER SOCIETY OF ONTARIO

**The Acting Chair:** We'll move to the next presenter, the Alzheimer Society of Ontario, Linda Stebbins, please. Whenever you are ready, you can start your presentation.

**Ms. Linda Stebbins:** Good morning, Mr. Chair.

**The Acting Chair:** Good morning.

**Ms. Stebbins:** Thank you so much for this opportunity to discuss Bill 140. As you mentioned, my name is Linda Stebbins and I'm the chief executive officer of the Alzheimer Society of Ontario. With me is David Harvey, who is our director of transformation and transition management.

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As you heard recently in the Legislature, last November marked 100 years since Dr. Alzheimer discovered the disease that remains one of society's most frightening diseases and about which major research efforts must continue. January is also Alzheimer Awareness Month, and so it seems a particularly fitting moment to have this conversation with your committee.

We will be providing the committee with our written submission, but today's presentation will address four questions: First, what is the burden of Alzheimer's disease and related dementias in Ontario and in the long-term-care homes in particular? Second, what credibility

does the Alzheimer Society of Ontario have in speaking about Bill 140? Third, what aspects of Bill 140 are distinct improvements for persons with dementia? And finally, what should be added to or amended in Bill 140 to better meet the needs of residents with dementia?

Let me begin with our first question: What is the burden of Alzheimer's and related dementias in Ontario and in the long-term-care homes in particular? In Ontario, 171,000 persons have dementia and this number is growing rapidly as the lifespan of our population increases. Over 50% of residents of our long-term-care homes have dementia and it is the major cause for admission. The average stay of persons with dementia in long-term-care homes is decreasing, with some homes having a 50% admission rate in one year. So people are moving into a home when their illness is at the most debilitating stage. The growing number of persons with dementia places pressure on both the space requirements and staff capacity of the homes.

The second question: What credibility do we bring in speaking about Bill 140? No one wants to get Alzheimer's disease, but if they do, our society's 39 chapters are there for them, their caregivers and for the health service providers in every community in our province. For nearly 25 years, we have remained true to this mission, as well as leading the way in supporting dementia research.

No one wants to live their last years or months in a long-term-care home, but if they must, our society will reach out to partners to ensure adequate staff training, informed and supported caregivers, and to create and disseminate research on better ways to provide care.

The Alzheimer strategy for Ontario that we, along with the government of Ontario and our partners, launched in 1998 continues its momentum. Among other initiatives, the strategy emphasized dementia education, physician education and advanced care planning. While more than 4,000 workers in long-term care have received dementia education over the last seven years, this remains a very small segment of the total workforce in over 600 long-term-care homes in the province.

Our third question: What aspects of Bill 140 are distinct improvements for persons with dementia? Let me begin with rights orientation. The rights-based approach taken throughout the legislation will do much, we believe, to assure that all of the activities of long-term-care homes have the resident as their primary focus. The fundamental principle set out in part I assures that a long-term-care home be operated, above all, as the "home of its residents."

Next, let me comment on consent. Especially laudable is clause 42(11)(d), requiring consent for admission to a specific home. You will hear at this table stories of people in hospital who have been forced to move 60 or more miles from their home and their loved ones to receive long-term care. This must end.

The provisions in paragraph 5 of subsection 43(1), requiring consent for admission to a secure unit, are very positive. Some may ask you to modify this provision because of convenience or ease of management. We ask

that you not do that. One of the great cruelties of dementia is that its progress is uneven. One part of a person's brain may be compromised, while another part may function adequately. We cannot prejudge the impact of an inappropriate placement in a secure unit on an individual.

Last week, we heard of an instance where an older, fully cognizant person in hospital was almost admitted to a secure unit, not because they needed it but because it was the first bed available. The hospital wanted the discharge, the home wanted to fill a bed, and the community care access centre was there to facilitate. Despite good intentions, systemic pressures can distort our judgments. The law is needed to prevent, quite frankly, abuses such as this.

Finally, let me tell you what we like about the classes of beds. Clause 178(2)(h), which calls for the classification of beds, will enable small behavioural assessment units to be established in at least one long-term-care home in each LHIN region, modeled on those already in operation in St. Catharines, Hamilton and Kitchener. Such specialized assessment units would do much to reduce the likelihood of severe aggressive behaviour.

Our fourth and final question, especially important for both the committee and the Alzheimer Society of Ontario: What should be added to or amended in Bill 140 to better meet the needs of the residents with dementia?

Regarding consent, because of the varying cognitive deficits of residents with dementia, we recommend that subsection 3(3) be amended to include the following: "In instances where a substitute decision-maker is acting for the resident, the rights of the resident may be acted upon by the substitute decision-maker." This amendment, in our view, will clarify the role of the substitute decision-maker within Bill 140.

As for training, we commend the bill's provisions on training. We have some concerns about the way section 74 is drafted so that all persons working in the home are subject to similar training requirements. We are concerned that the training requirements may discourage volunteers by requiring a training content that is excessively complex or onerous. Our society advocates that section 74 be amended to identify classes of persons who require training, and that the types of training are matched to each group's particular involvement with the resident population. This is an approach that is consistent with best practices in volunteer management. This change may also alleviate concerns of some providers about the perceived excessive training burden.

Finally, positive incentives: Bill 140 is based on a belief that inadequate care can be remedied by inspection and enforcement, but we contend that excellent care can only be encouraged through positive incentives. The bill needs to give more prominence to its provisions for the minister to recognize and reward excellence in all aspects of training, programming and management of long-term-care homes. Such initiatives as the Alzheimer Knowledge Exchange, the Registered Nurses Association of Ontario's best-practice guidelines and the proposal for

teaching long-term-care homes similar to teaching hospitals and health units are initiatives through which the minister can encourage the pursuit of excellence.

We recommend that clause 178(2)(r) be elevated to form its own clause and that subsection 141(2) be moved to this section. This change emphasizes the minister's obligation and ability to foster positive incentives.

Before concluding, I want to acknowledge the contribution of our working group to this presentation and to our written submission. They have urged us to bring to your attention the need for public consultation on the regulations that are so important to this bill.

As well, we cannot end before clearly stating our concern that the good intentions of you as legislators to ensure quality of care cannot be realized unless you also continue to provide adequate resources to enable front-line workers to succeed. Ontario may stand in front of the line for policies, but without an infusion of funding, it will remain far back in actual performance.

Mr. Harvey and I are prepared to answer any questions from the committee.

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**The Acting Chair:** Thank you. There are 30 seconds each. Ms. Smith, please.

**Ms. Smith:** Great. Thank you, and it's nice to see you again. I appreciate all the work you've done.

Just on the training question, we have heard those concerns about the levels of training required and about defining volunteers quite specifically. We are working to address that. Also, to let you know, as I did yesterday, we will be having public consultation on the regulations. So thank you for raising that as well.

I thought it was interesting timing that you would come to us and speak of the need for the consent provisions when we just heard a previous presenter discuss the inconvenience of or the paperwork burden of that requirement. Could you, in 10 seconds or less, kind of give me a bit broader reason or comments on why there is such an important need for consent in moving to a secured unit?

**Mr. David Harvey:** First of all, removing the right to freedom of movement is—that is a fundamental right. That should be seriously considered. So that's the first point.

The second point is that there can be an uneven impact in dementia, as we mentioned. So one might think that a person may not be very aware of the impact of certain decisions being made, but in fact they may experience it very profoundly.

So those are our two major reasons: It's the gravity; and the impact can't be predicted.

**Mrs. Witmer:** Thank you very much for your presentation. You've reiterated what we've heard repeatedly, that the act is really quite punitive, that it focuses on inspection and enforcement, and there's a need for balance and more incentives. Can you expand? You've given examples here of some things that could focus more on the positive initiatives. Is there anything else you'd like to say in this regard?



**Ms. Stebbins:** We really think that getting to excellence requires other measures and that there need to be rewards in place for the really excellent service that is delivered in many of our homes across Ontario, and that does seem to be missing.

**Ms. Martel:** Thank you for your presentation. Under "classes of beds" on page 3, you say that clause 178(2)(h) will allow for specialized assessment units. I've read the section. I don't see where that comes in at all. There's no reference to that. Did someone tell you that? Is that what happened?

**Mr. Harvey:** One might see things where they maybe don't exist, but it does give the power to the minister to create different classes of beds. One might think of that as only preferred accommodation, for example.

**Ms. Martel:** Yes, that's right.

**Mr. Harvey:** But there are instances where there are dialysis units, for example, in long-term-care homes. So that opportunity to diversify service, I think, can be read into that section.

**Ms. Martel:** So you hope that's what it means.

**The Acting Chair:** Thanks very much for your presentation.

#### HERITAGE GREEN NURSING HOME

**The Vice-Chair:** Next, Heritage Green Nursing Home. You can start whenever you're ready. Can you state your name for Hansard, if you don't mind.

**Ms. Rosemary Okimi:** Good morning. I'm Rosemary Okimi. I'm the administrator of Heritage Green Nursing Home. With me is Scott Kozachenko, the assistant administrator.

We thank you for the opportunity to speak to your committee today on behalf of our facility and all other similar facilities in the province. Scott will give you a little history of our facility and some of the things we're facing, and then I will follow with some additional remarks.

**Mr. Scott Kozachenko:** Heritage Green is a non-profit home for 167 residents that provides jobs for 200 staff in Stoney Creek and surrounding region. For approximately 24 years, Heritage Green has been providing a continuum of care to neighbouring communities. Families rely on the care provided in our senior apartments, retirement home and nursing home.

The nursing home has an occupancy level of almost 99%, a waiting list that averages 75 on any given day, and an aging population that continues to look to us for long-term-care services to meet their immediate and future needs. Our board and staff have an ongoing commitment to meet these needs. This commitment is stronger today because of the relationship Heritage Green has built between our residents, their families, friends and community at large.

We are here today to ask you to amend the limited licensing provisions in Bill 140 and provide the plan to support us in keeping this commitment. The issues that this section creates for us in our efforts to develop our

home to provide the physical comfort and dignity our residents need are as real for Heritage Green as they are for any other home in the province.

Although Bill 140 is not yet law, the uncertainty created by it has already impacted our decision-making.

Heritage Green Nursing Home has three floors. The first and second floors have existed since 1991, while the third floor is new and was added in 2003. Overall, we are structurally classified as a B home because we have three-bed ward rooms and over 50% of our residents have to take the elevator down to the dining room on the first floor.

As a board and management group, we have been dissatisfied with our structural situation for several years and have been looking for ways to improve the comfort and privacy provided to some of our residents. Early in 2006 we began to actively pursue solutions to address these physical comfort and privacy issues for our residents. We conducted a feasibility study and worked with architects to develop a viable solution with the hope of beginning to move forward this coming May.

Our solution was projected to cost just over \$2 million, not huge as building renovation and redevelopment projects go but still significant for a 167-bed long-term-care home. Our board, residents, families and staff are now most disappointed that we are not able to proceed. We're financially stable, yet we're unable to obtain the financing within our current circumstances. With the uncertainty in Bill 140 and the absence of a government commitment to a capital renewal program, I am not sure when, or even if, we will ever be able to proceed.

**Ms. Okimi:** Over the past few years we have seen the amount of care we can provide based on ministry funding decline through the combination of a lower CMI and increasing wages and other care costs. Even though this was the case, our board was not prepared for our staffing and care levels to fall any lower than they already are. I think everyone in this room today agrees that more needs to be done to address this issue. And while we are talking about that, I might add that in the context of your deliberations on this bill, the extra paperwork and other administrative requirements it will require are only going to make the situation even worse.

In order to sustain our care levels, our board has approved us to overspend our nursing and personal care envelope by some \$200,000 annually. These funds are generated by the resident co-payment and fundraising activities. We also use this funding to pay for things like administration, dietary workers, building and grounds maintenance, cleaning and utilities.

I should also point out that in addition to the other requirements for this funding, our management flexibility is further limited by the fact that, with an existing mortgage, our bank requires us to maintain a surplus financial position.

Over the years we have been able to meet all of these commitments and requirements and, with careful management, accumulate investments and reserves in the range of \$1 million. This was not sufficient to provide the

bank with the comfort to finance our proposed \$2.1-million retrofit proposal. Since we would be adding very little additional revenue generation opportunity, they asked us to increase our surplus by another \$200,000 before they would be comfortable in granting financing. We were left with three unworkable and/or unsatisfactory options.

Option 1 would be to lay off staff and reduce our current care and service levels. We do not think this is an appropriate trade-off, and neither do our residents, families or staff.

Option 2 would be to go to our donor community and try to raise the additional funds. This is a major challenge at the best of times. As we considered this option, our prospects for success dimmed significantly with the tabling of Bill 140. Putting a deadline on our operating licence without identifying what we would have to do to ensure our licence is renewed, or identifying how long our licence would be renewed for even if we did what-ever it is the ministry will tell us to do sometime over the next nine years, is hardly a story that will foster donor confidence and support.

1100

Donors, like any other investor, want reassurance that there will be a long-term return to the community on their investment. With the current uncertainty in Bill 140, we would be unable to provide that reassurance, particularly to the point of convincing them to make multiple-year commitments. As I'm sure you are all aware, multiple-year commitments are an important factor in donor-funded capital projects.

Our board also realized that the same uncertainty in Bill 140 that would make our donors more reluctant to give would also increase the amount we would have to raise. With no reasonable degree of assurance that we would either exist or have the same revenue-generating capacity we have now because we could have fewer beds, our bank would require an even larger surplus before being comfortable in extending us financing. That is just financial reality.

Thus we were left with option 3: maintain our current staffing levels and do nothing structural, and thus maintain an unsatisfactory status quo, despite our committed best efforts to do otherwise.

We are hoping that over the next few days you will take steps to ensure that this is not the status quo when Bill 140 becomes law. We ask this so that Heritage Green's residents can look forward to having, at most, two people to a room, and to not having to line up in their wheelchairs to take the elevator down to the dining room for every meal.

But we also ask this on behalf of all communities, residents and families who depend on the care and services provided by B and C homes. They deserve to know that the home will continue to exist and that it can provide them with the physical comfort and dignity they deserve.

The solution starts with amending section 180 to provide us with a 15-year term licence and to empower

government to fund a capital renewal and retrofit program for B and C homes. As you can see, we are the perfect example of why this program needs to include an option to retrofit as well as fully rebuild.

These amendments need to be supported by an immediate government commitment to work with the sector to implement such a program over the next 15 years. With these elements in place, we would gladly commit to being held to this deadline as a condition of licence renewal, a renewal that should be for the 25 years that Bill 140 would give new homes.

Section 180 of Bill 140 needs to be further amended to provide the predictability of 10-year rolling licence renewal periods following this 25-year term. These renewals should be tied to operator performance and bed requirements in addition to the building structure.

I know that our association, the Ontario Long-Term Care Association, has presented this solution to you in detail. On behalf of our board, residents, families and staff, I urge you to give it your full consideration. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can divide it equally among the three parties. We start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. I think that you've certainly emphasized the hardships that are going to be created by this bill: the amount of paperwork, the punitive approach, certainly, and also the inability to focus on eliminating the three- and four-bedroom wards that exist throughout the province of Ontario.

Looking at this bill, what is going to have the most profound impact on residents in your particular home and the level of care that is going to be declining?

**Ms. Okimi:** Partly, the paperwork is really going to make a lot of difference. Our registered staff are stretched to the limit with all the requirements that are already in place. Every time you add another layer of paperwork, it detracts from the amount of care that can be provided to the resident.

Also, there is the uncertainty as to whether we are going to be able to do the renovations that we so badly need so that our residents can have the privacy and dignity that we would like to provide them with.

**The Vice-Chair:** Thank you very much. Ms. Martel.

**Ms. Martel:** Thank you for your presentation here today. I appreciated the solutions that were offered with respect to the licensing section. I had read some of that already in the ONS brief.

This may be premature, you may not have done this yet, but in terms of the bank you deal with, have they seen those proposals and given you any sense that if adopted or accepted, they would then be in a position to help you? But that may be premature.

**Ms. Okimi:** We did talk to the bank and we did ask them, with the proposals that we have, and their bottom line was that we didn't have the operational surplus to support paying back a \$1-million loan.



**Ms. Martel:** So it's the surplus that they're focusing on?

**Ms. Okimi:** Yes. Right now, we are required to have a surplus because of our existing mortgage—a 1.25% debt service ratio. But we barely make that. That isn't enough to support the additional borrowing.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** We've heard a lot about the paperwork issue and I wonder, as an administrator, if you could outline for us exactly what provisions in the legislation you feel are onerous and will contribute to your paperwork.

**Ms. Okimi:** I can't tell you chapter and verse, but I do feel that the fact that there will be much more reporting on each of the new standards and much more accountability—and accountability is good; I have no problem with accountability. But the more we have to document exactly what was done, it just keeps adding more and more.

**Ms. Smith:** Is there any specific area where you feel that more has been added? We have heard about the rights advice for going into secure units; we heard some concern yesterday around the documentation around restraints. But other than that, most of what's in the legislation is already required in policy as far as documentation. Is there any other area that you find is going to contribute?

**Ms. Okimi:** Not different to those areas that you have talked about, but again, a little bit more reporting on those areas.

**The Vice-Chair:** Thank you very much for your presentation.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, ONTARIO DIVISION

**The Vice-Chair:** The next presentation will be by the Canadian Union of Public Employees, Ontario division. Welcome. You can start whenever you're ready. If you don't mind, can you introduce the people on both sides?

**Mr. Sid Ryan:** I certainly will. My name is Sid Ryan. I'm the president of CUPE Ontario. To my left is Judy Wilkins. She's our legislative assistant. To my right is Brian Blakely. He's a researcher with CUPE.

I want to thank you for the opportunity to make a presentation here today on behalf of CUPE's 200,000 employees, 26,000 of whom work in the long-term-care sector.

I just want to preface my comments by saying that once in a blue moon a piece of legislation comes along that I would hope we'd be able to deal with in a somewhat non-partisan way. I believe Bill 140 is such a piece of legislation. It's clearly time for us to take a look at the needs of residents in these homes and say that the grand experiment of the last 10 or 15 years has failed miserably. I'm referring to the time when the Mike Harris government took away the minimum standards in this province and left us to our own devices, if you will. It's proven to be a failure and I do believe that it's time we once again got back into taking a look at reintroducing

those standards which were taken away so many years ago.

Bill 140 will affect, in our opinion, not only the workers but over 75,000 family members and loved ones in those long-term-care facilities, both today and for decades to come. So we have an opportunity now with this legislation, which probably won't get opened up again for the next 20 years. I do want to thank the Liberal government for taking this on. It's a piece of legislation that desperately needed to be revamped.

I also want to say that we've had good access to the Liberal government with respect to our viewpoints. We've got a lot of workers on the front lines who are working in this system and have come forward many, many times with complaints.

We submitted a document to the minister and to the parliamentary assistant, Monique Smith, a couple of years ago, a lot of which we see in the legislation, and we're thankful for that. We think they're obviously listening. There's still a bit more work to be done and I'm hoping that over the next few days and weeks, as these hearings proceed, we can make those changes.

#### 1110

Our brief is premised on a brief that was written for us by two professors, Pat Armstrong and Tamara Daly, where we interviewed 900 front-line workers to get an up-close view of what's taking place in long-term-care facilities. The survey reinforced the claim that the workload is simply too heavy to allow for a safe and healthy workplace for providers or a home space for elderly and frail residents.

Some of the findings are quite startling, actually. There was a time when front-line workers were able to actually sit down and talk to residents, certainly those residents who don't have family members come visit on a regular basis. So even just a simple chat was part of the daily workload in many respects. Some 70% of our members are reporting today that that whole issue has just disappeared, that there's no time any longer to even chat with the residents; 60% of the time workers don't have time for emotional support; 53% of the time walking and exercising of residents is not done; more than 40% of the time foot care is left undone; and 20% of the time turning residents, bed-changing, room and bathroom cleaning remains undone.

That's a horrible indictment. That's the legacy in many respects of the Harris government of removing standards, that 2.25. I'm sorry to see that Mrs. Witmer has left her seat. It's part of the legacy that this government left us and it's proven to be a horrible exercise over the last 20 years.

In the 1990s, as I indicated, the Harris government eliminated the provincial requirements to provide every resident with a minimum of 2.25 hours of daily personal care. While Harris was busy eliminating Ontario's standards, 13 US states were actually increasing their standards. Today, 37 jurisdictions in North America provide a minimum standard of care. That's why CUPE's whole presentation is premised on this whole question of standards.

There are three priorities that we're looking at. One is adequate standards of care, which we believe to be 3.5 hours of nursing care on a daily basis for every resident; safety from violence; and building a culture of respect and openness in the homes.

Adequate standards of care: Bill 140 abandons a promise that the Liberals made to re-establish care standards, and I'm certainly hoping that before these hearings are over they will live up to that commitment. CUPE workers really love their work, but go home feeling badly every night because there are not enough hands to provide the care residents require. For example, feeding patients in a line is something that has come forward many, many times, both in these hearings and from our members; or receiving this bath in a bag leaves our members feeling frustrated and, quite frankly, broken-hearted to see this kind of treatment of the elderly in their homes. That's got to stop and we've got to have minimum standards that allow the workers to provide a level of dignity and respect to the elderly who are living in these homes.

In 2001, a PricewaterhouseCoopers report found that Ontario lagged behind all other similar jurisdictions in care levels and therapies, while having significantly older residents with complex needs. That's why CUPE is recommending a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per resident.

The bill needs to be amended to provide that the provincial government is required to create and maintain a provincial funding model that is based on a uniform assessment tool across the province to ensure there are uniform provincial standards and funding assessment tools across all of the LHINs, if these nursing homes get rolled into the LHINs. I will say that we know and are aware of a pilot project the Liberal government is engaged in, and we're hoping the results of that will result in a new assessment tool that will more adequately assess the needs of residents in the homes.

In terms of violence, I want to touch upon this because it's an issue that comes up with our members on a regular basis. It must be recognized that these facilities are not just homes, they are also workplaces for thousands of care workers and caregivers. These are workplaces where incidences of violence have actually continued to increase.

In 2004, residents attacked other residents 864 times and attacked staff 264 times—a tenfold increase in a five-year period. Much of the cause is from aging, chronically progressive diseases and age-related dementia. But nonetheless, Bill 140 needs specific amendments requiring that homes be safe and secure for residents and for staff.

We had some recommendations in our brief, particularly around appropriate training guidelines and approved training opportunities for staff and even the operators of the facilities: clear guidelines for admission of residents with dementia and cognitive impairment and aggressive tendencies; the establishment of care plans for those with a history of violence prior to admission; and a stop to

inappropriate downloading of patients from mental health facilities and acute care facilities into long-term-care homes.

Finally, we need to have a culture of respect. There's a significant consensus that Ontario's long-term-care homes require a cultural shift. The legislation must include a recognition that the homes are both homes and workplaces, that staff should be treated as partners in setting and protecting care standards. That's why we believe the bill should go much further in addressing the casualization, for example, of work, discrimination in the workplace and whistle-blowing.

I just want to touch very briefly on the whistle-blowing. We are pleased to see that it's in there. We think it could go a little bit further, because the way we read it, it could mean still that one of our members who would come forward to blow the whistle may in fact still end up getting fired and have to go through the process, either to the Human Rights Commission or to the grievance procedure, to get their job back. We think that should be tightened up. Let's not leave any of those loopholes.

Finally, I'd just like to say that here's an opportunity—the last time possibly in the next 20 years—so let's get this bill right. We're halfway there; we're not fully there right now. If we can introduce the standards, take a look at the homes as a workplace as well as a home for the residents and strengthen the whistle-blower protection, certainly we as a union would be pleased with that. We still hope there's some time when we can continue the dialogue that's going on between ourselves, the Liberals and anybody who wants to listen in terms of our position.

So with that, I thank you for the opportunity to make this presentation today.

**The Vice-Chair:** Thank you very much. We have five minutes left. We can divide it equally among the three parties. We start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I want to focus on standards, as I have been for most of these hearings. First of all, the Liberals were very clear that they were going to re-instate minimum standards. That was an election promise. We are in the fourth year of the government mandate, and we haven't seen anything yet. If there was going to be a change, you would have thought it was going to come in this legislation. So I am going to be putting forward an amendment that will recommend 3.5 hours of hands-on care per day, and we'll see what happens then and who votes for what, when.

The second standard I want to talk about focuses on safe environments and making sure that there are appropriate levels of staff to deal particularly with residents who are violent and have a history of dementia. The Casa Verde inquest had a very specific recommendation with respect to that. It said that if a decision is made to place these individuals—that is, people who are violent with dementia—in long-term-care facilities, the Ministry of Health “must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have



expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self or others.” The ministry’s response was, “The ministry is currently considering these recommendations.”

It seems to me that if you are bringing a long-term-care bill forward, you would have implemented that recommendation too if you had the intention of doing it in the first place. So we will be bringing a recommendation forward in that regard.

Maybe you have some other information that would suggest that the government is going to move on these two important matters. But, to date, we don’t see any evidence that the government is intending either to reinstate a minimum standard of care or deal specifically with clients who have dementia. What gives you any hope or confidence that we might see a change of heart in this regard?

**Mr. Ryan:** Well, I’d be foolhardy to say that I’ve got additional information when I don’t. The only thing I can base it on is my experience in dealing with all three parties when they were in government. We had excellent access to your government, Shelley, when you were in office. We had hardly any access to the Tory government, who just went ahead and eliminated this without consultation with anybody in terms of standards. We’ve had good access to the Liberal government in the last little while in terms of being able to work with them. I have seen some of CUPE’s material, which we presented a couple of years ago, appear in this legislation, albeit in a different forum. So I’m optimistic. As a union leader, we like to use that “cautiously optimistic” expression, but I am optimistic that the Liberals will listen to the preponderance of presentations that have been made, not just by CUPE but by others who are calling for these standards. I think it would be swimming upstream if we saw anything less than the kinds of recommendations that have been made both by CUPE and the majority of the presenters here over the last number of days.

1120

**Ms. Smith:** I just wanted to address some of the issues that you raised. You talked about training and the need for appropriate training. We do outline that in section 74.

You talked about guidelines for admissions of residents with dementia and cognitive impairment. You’ll see in section 41, on admissions, that we do talk about a fairly thorough assessment prior to the applicant’s placement in a home, including looking at their current behaviour and their behaviour in the year preceding, in order to do a more broad assessment of their behaviour and to try to address any history of violence that we may have to address.

With respect to the plan of care, you talked about staff collaboration. In section 6, we certainly set out that all staff who are involved in the care of the resident be involved in developing the plan of care.

You talked about your concerns around agency staff. We do address the limiting of agency staff in the legislation.

I do take your comments on the whistle-blower protection and wanting to see that strengthened, but it is in fact in the legislation, as you requested a couple of years ago when we met.

My one question for you is—you talked about 37 jurisdictions that have adopted a minimum standard of care. My information—and it is kind of difficult to pull it all together—is that there is only really one jurisdiction in Canada that has a minimum standard. That’s Alberta, which has set a minimum standard of 1.9 hours of care and a target of 3.4, not a minimum standard. Sorry, there are two. Saskatchewan has set a minimum standard of two hours of care per resident. There are a couple of other jurisdictions that have talked about implementing it, including New Brunswick in their recent campaign, but we haven’t actually seen that legislated. Do you have other information that would indicate that there is broader acceptance of legislated, or in regulation, minimum standards across the country?

**Mr. Ryan:** Just to the comments that you made to preface your question, part of the reason that the whole question of standards with respect to violence is in our presentation is that we recognize that there’s always a pushback from employer associations that don’t want to see any standards. They want to align themselves where the Conservatives were 12 years ago, which is, “Let’s eliminate standards.” We know that has been a failure. So we want to make sure that when standards are implemented—and I recognize that they are mentioned in your bill, but they need to be broadened. We want the workers to be part of a bipartite process, if you will, in terms of developing what those standards would look like, as we have in many workplaces when it comes to health and safety.

So it’s a recognition that it’s in the bill but not as strong as we would like it, but it’s also to send a signal to those employers that they just simply cannot have it their way on every front. You cannot say, “Eliminate standards of care,” which has been a disaster, and at the same time, “Also, let’s eliminate all of the paperwork, and let’s eliminate all of the accountability mechanisms that we build in. Also, let’s eliminate where we sit down with workers and actually take a look at what standards would look like with respect to violence.” That’s the reason why it’s in there.

In terms of Alberta, for instance, I think your information is wrong. We’ve just gone and checked in the last number of days, and in fact Alberta has legislated 3.6 as the minimum standard. I know at one time they were talking about moving towards a target, but the information we’re getting from Alberta is that they have legislated it.

**Mrs. Witmer:** This is a different Sid Ryan we’re hearing from today. I think you might become a Liberal candidate in the next election campaign. You’re so assured that all of the recommendations that you’re putting forward are going to be implemented into law by the Liberal government. If that were the case, I don’t know why they didn’t put it in the original bill.

Certainly, this is a different presentation than those we've heard from other union members. You maybe have had a private conversation recently with the Liberals that would lead you to believe all is going to change. Might that be the case, Mr. Ryan?

**Mr. Ryan:** Actually, Mike Harris asked me to run for the Conservatives at one time, so I don't know where you're coming from with that particular question. My roots are well known to all and sundry in this province.

Sure, I've had discussions, like anybody else has had. As I go in the door, I find all kinds of people together; it's a revolving door in the ministry. Of course, we do what we do best: We talk to government. We get the opportunity to speak to government, unlike yours, when you were in office. I'm sorry, Elizabeth; you had a closed-door policy, except when it came to the employers. There was an open-door policy and open season in that respect.

We are talking to them. I'm not saying we're going to get everything we want. As a matter of fact, I'm heading down to Niagara this afternoon to organize a press conference and a protest. I'll be doing the same in Windsor tomorrow, and in North Bay today there's a protest. So we're not backing off. We're saying, "Look, we want these standards implemented." By the same token, I am recognizing that the ministry is listening to our concerns and I am seeing already portions of CUPE's issues being reflected in this legislation. I'm not talking about since the bill got introduced; I'm talking about from presentations that we made two years ago. I'm acknowledging that I'm seeing some of that, which I never saw in any legislation that your government ever brought forward.

So from that respect I'm saying, yes, I'm optimistic that, given not just CUPE's presentation here—I understand there are all types of folks coming to these presentations asking for these standards—that this government will listen. And listen, if they don't come forward in the next little while, we have from now until the Legislature opens at the end of March to continue to mobilize the sector and the community and the residents and their loved ones. There's lots of opportunity and lots of time. So, having been around the block a few times, I understand how the process works and right now I think it's the time to listen, to make our presentations. If the Liberals pick up on what we're saying, good for them. That's an excellent first step on a piece of legislation that I really do believe should be approached in a non-partisan way. I honestly believe that. There are certain pieces of legislation that just don't lend themselves very well to partisan politics, and this is one of them.

**The Vice-Chair:** Thank you, sir, for your presentation.

#### ALLIANCE OF SENIORS

**The Vice-Chair:** Now we move to the Alliance of Seniors. Are they around? You can start whenever you are ready.

**Mr. Al Gorlick:** Good afternoon, ladies and gentlemen. Thank you for the opportunity of making a presentation today. By the way, my first comment is going to be that I have a vested interest in the outcome of this legislation because my wife, who has Alzheimer's, is a resident in a long-term-care facility with which I have a lot of experience. I'd like to have that upfront so that there won't be any misunderstanding.

The Alliance of Seniors, founded in 1993, is an active, diverse and growing non-partisan coalition of individuals and organizations representing the concerns of over 300,000 older adults residing in the greater Toronto area.

Our mission is to preserve and enhance Canada's social programs on behalf of the present and future generations; to promote a society where all persons have an equal opportunity to live with dignity, to realize their potential and to participate in the democratic process; and to educate and raise public awareness about the values, life experiences and lessons learned by we Canadian older citizens.

As a coalition, the alliance does not presume to speak for each and every individual participating organization nor represent their specific positions. Rather, the alliance seeks to build consensus upon the shared values amongst these groups when addressing issues of mutual concern.

I'd like to bring to your attention the number of senior organizations and individuals who belong to our group: the Association of Jewish Seniors; the Bernard Betel Centre for Creative Living; the Canadian Institute of Islamic Studies and Muslim Immigrants' Aid; Canadian Pensioners Concerned; Care Watch Toronto; Caribbean Canadian Seniors; Concerned Friends of Ontario Citizens in Care Facilities; Congress of Union Retirees of Canada; Elder Connections; Habayit Shelanu Seniors; Jamaican Canadian Association; Korean Inter-agency Network; Older Women's Network; Ontario Coalition of Senior Citizens' Organizations; Ontario Federation of Union Retirees; Riverdale Seniors' Council; Toronto Seniors' Assembly; Yee Hong Centre for Geriatric Care.

I hope you're impressed with that list.

#### 1130

The Alliance of Seniors, its affiliates and friends endorse the principles of the Canada Health Act: comprehensiveness, universality, accessibility, portability and public administration. I have the honour of being the chair of this organization. Thank you very much.

**Mr. Derrell Dular:** That's Al Gorlick, chair of the Alliance of Seniors. I'm Derrell Dular, general secretary and executive coordinator for the organization.

We are generally pleased with the government's demonstrated intent in Bill 140 to improve the legal framework for the regulation of care and services for residents in long-term-care facilities. However, we do have certain reservations regarding provisions that leave some essential matters to be dealt with by regulation, while the availability of appropriate funding is to be the determinant for the implementation of other key elements.



Adequate and meaningful public consultation should be a prerequisite to the drafting of the act's regulations if the legislation is to live up to informed public expectations.

Appropriate funding should be assured for the mandatory training of all direct care staff in specified areas, such as dementia care and behaviour management, rather than relegate this provision to a conditional option if funds are available.

Fundamental to the quality of life afforded to persons resident in Ontario's long-term-care facilities is the provision of sufficient personal care to meet the individual needs of each and every resident. To address this necessity, we believe that a province-wide minimum staffing standard for residents' nursing and personal care needs must be reinstated in Ontario.

It must also be recognized that since the previous minimum standard of care, that of 2.25 hours per person per day, was eliminated in 1996, the composition of the resident population in long-term-care homes has generally become older, with increased care needs. Today, without a minimum standard requiring an adequate staff-to-resident ratio, many residents' care needs go unmet, jeopardizing their health and their very lives, as has been documented in the media.

Following consultation with affected parties and our various participating organizations, the Alliance of Seniors recommends that the government undertake to adopt a minimum standard of personal care averaging 3.5 hours per day per resident. We further recommend that the ministry fund each facility on the basis of its real assessed needs, given that individual needs vary and so does the mix of residents' needs in each facility.

In light of Canada's aging population and as all long-term facility beds receive public funding, we recommend reinstating the minimum standard for facilities requiring that at least 60% of beds be for non-preferred accommodation.

To help ensure quality care and value for our tax dollars, we also recommend strengthening family councils and their reasonable access to information; further consultation on the appropriate use of restraints; better training for front-line personnel; continuing unannounced inspections for all facilities, at least annually or in response to formal complaints; and effective sanctions for facilities demonstrating consistent non-compliance with regulations and standards.

We thank the committee for this opportunity to express our support for and concerns about Bill 140.

Before we accept your questions, I would like to advise that despite a generation age difference between myself and our chair, Al Gorlick, we both have loved ones who are resident in long-term-care facilities: in Al's case, his wife and life partner of over 50 years, and in my case, my mother.

**The Vice-Chair:** Thank you very much for your presentation. We'll start with the parliamentary assistant.

**Ms. Smith:** I thank you both for being here. Al, did I see you on TV this week? Were you talking about the legislation? Good to see you. Thank you for coming.

We appreciate the recommendations that you have made. I think you'll find that in the legislation much is addressed. I said publicly yesterday and again today that we will be consulting on regulations in order to address that concern.

Section 74 of the legislation does require that direct care staff receive training in dementia care and behavioural management, so those aren't conditional options but they are requirements in the legislation.

You also spoke about the need to fund a facility on the basis of real assessed need. I think you're probably aware that we're moving towards the MDS model of assessment in our homes for our residents, which will give us a clearer, more up-to-date picture on the actual needs of our residents at any given time. That started as a pilot project under our government by the ministry and has moved now to about—I think 160 homes are now adopting MDS, as opposed to the CMI process. We're hoping to, over the next couple of years, roll that out to all of our homes across the province.

With respect to your recommendation on family councils, as you're probably aware, the Liberal government funded the family council project and ensured that we had the support needed across the province to assist in the development of family councils in various homes across the province.

In the legislation, we set out the criteria for family councils. We restrict membership to those who are really involved in the home, in the lives of the residents, so we don't have staff interference. We provide a mandate for our family councils and encourage them to be created. Where they're not created, we encourage homes to come back to family members on a regular basis to tell them of the possibility of creating one and to encourage them to do so.

With respect to your recommendation on the appropriate use of restraints, I think you'll see in the legislation a fairly detailed protocol on minimizing the use of restraints, and when they are used, there is a very detailed protocol on how they can be used.

Again, front-line personnel training we do address. And we will, obviously, because it's mandated in the legislation, continue with unannounced annual inspections, except in exceptional circumstances, which are going to be defined in the regulations, which may be in order to recognize some homes that have had no problems and that we want to recognize as being really great homes. But of course, we would still be in to the home with an inspector if there was any issue or problem reported.

**The Vice-Chair:** Thank you very much. Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation, Mr. Gorlick, and also Mr. Dular. It is a very impressive list of organizations and homes that you do represent.

I appreciate your coming forward. Certainly we've heard from the government what the bill is proposing to do, but I guess we've also heard that contained within the bill there's a tremendous amount of paperwork. It takes a

very punitive approach in the area of enforcement. Also, for many of the changes in the legislation, in order for it to be successful it's going to require a significant increase in funding. You've indicated here that you want to see the minimum standard of care increased to 3.5 hours per day. Of course, none of this is going to happen without any funding, nor can the huge paperwork burden be achieved without impacting on care if the government doesn't give funding.

You've talked about mandatory training for staff. I think that's very, very important. In fact, we've heard from people who have come before us that the personal support worker needs training and needs education. We've heard about some of these individuals not having basic literacy and numeracy skills and the fact that they all need to be sensitive to the needs of the residents in the homes.

I think key to the success of this bill, which needs a dramatic overview, is going to be government assurance that for all of these activities and for all of these changes to have a good impact, there's going to have to be appropriate funding provided. As of now, we've not been assured that that's going to happen. That's key.

I appreciate your bringing forward your concerns and recommendations, and I trust that the government will provide the funding that is going to be needed to achieve any success at all.

**The Vice-Chair:** Thank you, Mrs. Witmer. Ms. Martel?

**Ms. Martel:** Thank you for your presentation here today. I want to focus on your concern about appropriate funding being assured for mandatory training so that people have training in dementia care and behaviour management. This is not conditional.

I noted with some interest that the parliamentary assistant took you to section 74 that says that every licensee in a home shall ensure that all staff have the training that's required to deal with all of the people who are coming in. She didn't talk about section 88, the funding section, that says, "The minister may provide funding for a long-term-care home," meaning may provide the funding that will allow for this training.

1140

**Mr. Dular:** That's why we perceive it as optional.

**Ms. Martel:** So your reference to optional was—

**Mr. Dular:** —was the "may" rather than an imperative.

**Ms. Martel:** I'm glad you clarified that, because this is a concern that has been raised by a number of people in terms of the "may" that should be "shall"—"must" is another requirement—and that the government actually does this, because it is very clear that despite promising \$6,000 more care for each resident in each long-term-care home, the government has delivered about \$2,000 of that. For any of this to fly in the way that the government proposes, it's going to be critical that the government actually meets its election promise and provides the \$6,000.

Can I just go back to your concern about restraint, because you said, "Further consultation on the appro-

priate use of restraints." I'm assuming you've read the bill but you have ongoing concerns about what may be missing or what is in the bill regarding that. Can you provide any further clarification?

**Mr. Dular:** In general terms, particularly for Al and myself, this is a very personal matter rather than a political or academic exercise. We are concerned that there be adequate consultation with the broader community, not just the professionals involved in the care of the residents of these homes. Our concern is basically that we be consulted and that people outside of the industry be consulted in establishing what is reasonable restraint under what circumstances.

**The Vice-Chair:** Thank you very much for your presentation. Now we move to our next presentation by—sorry, there's not much time left, sir.

**Mr. Gorlick:** Is there a minute left?

**The Vice-Chair:** No, no time left. My apologies. Thank you very much anyway.

## AURORA RESTHAVEN

**The Vice-Chair:** We move to Aurora Resthaven. Welcome. You can start whenever you are ready. Please state your name before you start, if you don't mind.

**Ms. Edith Schultz:** I'm Edith Schultz, a registered nurse and administrator of Aurora Resthaven, and beside me is Jill Knowlton, a registered nurse and regional director for Aurora Resthaven. We are a 240-bed home that has been providing care and services to Aurora and nearby communities for 32 years.

We are in a unique position. Up until 2003, we were a 176-bed C home. In 2003, we opened 64 new beds attached to the original home as part of the government's 20,000-bed expansion program. This expansion was made possible through a financial partnership between the government and the operator.

While this expansion was necessary and beneficial, it also created the reality of residents and families experiencing the oldest and the newest of Ontario's long-term-care accommodation standards in the same home. We are a living example of this double standard that applies to over half of the residents and their families in long-term care. In our home, residents and families see and experience the difference every day, even though they pay the same fees.

I want to bring this unique perspective to you today to do two things. First, I want to assure you that the residents and their families find this double standard unacceptable. It does not and it cannot meet their expectations for what a long-term-care home should provide in terms of resident physical comfort, privacy and dignity. Second, I want to assure you that without changes, Bill 140 will ensure that this double standard will continue for at least the next decade, with no certainty about what happens then.

Let me begin to try to paint a picture of what the double standard looks like.



The residents in the original building who want to share a room with one person pay a semi-private rate. They have a much smaller room, share a bathroom with three other residents and have very limited space for any personal belongings. In the new part of the home, there are no semi-private beds. Sharing a room with one other person is a basic or standard room with a reduced rate. These rooms are much larger, with extra space for personal belongings, and they share a bathroom with one person. It is most undesirable to rent a semi-private room in the original building when you may have a two-bed room in the newer area for less money.

Two home areas—120 residents—from our Mill Street side must take turns to use the same dining room for all their meals. This means transporting 60 residents per meal by elevator, causing waiting times for meals and to get to and from their home areas. Residents living in the new part of the home have a dining room on their home area, and it serves 32 residents with no waiting times.

The area that is of grave concern is the 60-bed dementia care home area, with more narrow hallways than in new design standards, small bedrooms that mainly hold four beds, and one common room that is used for all services. In contrast, the new dementia care home areas have large bedrooms and many common areas, like activity rooms, dining rooms, sitting areas and large hallways with continuous walking paths for residents.

Now, let me give you the issues this creates for residents and families. Constantly, when residents and families come for an initial tour to visit the home, their first request is to be admitted to the new area of the home. When they learn there is a waiting list, they are most disappointed with the process of being admitted to the original building and then transferred later when a bed becomes available. Residents and families cannot understand why residents who are paying for private, semi-private or basic accommodation in the original home are receiving less for their money as compared to residents in the new part of the home. These residents have their own dining rooms, lounge area, activity area and outdoor seating area on each home area, and may go freely about their areas without relying on others and elevators. In the original building, just manoeuvring the more narrow hallways is a challenge, and they must leave their units for any extra space.

Our home has one of the largest home areas—60 beds—for dementia care, serving the assessed needs of our community. Our home meets C standards but there is limited space in the bedrooms, contributing to very close living quarters and the challenge of providing much-needed quiet and privacy. A key factor with the limited personal space is the ability to meet the basic resident right of being able to have your personal possessions and furnishings displayed in your room. These residents are so restricted in their space that only minimal personal items can be allowed, to ensure the safety of others, a factor which is not an issue with homes built to the new design standards.

Further, the multi-purpose room, which is 625 square feet, is used as a lounge to visit with family and friends, a room to watch TV, an area for activity programs and entertainment, and then it is utilized as a dining room, where food is served to only 20 of the 60 residents at a time due to lack of space.

In 2007, our most frail residents have to wait for several meal settings. Many of these residents waiting for their mealtime require redirection from the dining room while others are being served. This home area has limited quiet or small private areas for residents to enjoy personal time or small group activities.

Families and residents are devastated when they see this area for the first time. The staff has spent countless hours reassuring families. Consequently, they have a favourite statement: “We are not a pretty environment or sight, but we are the best care there is.” Families who get to know the level of care provided to their loved ones support this statement and cannot understand why the government is not taking action but is allowing residents to live and staff to work in this inadequate environment.

I am very passionate about the care given to residents with dementia. In fact, I am so passionate I wish to invite you to come to our home and join myself and the residents for dinner. Seeing our environment first-hand is worth a thousand words. This is your opportunity to see, understand and take action while you are in a capacity to do so. It is without a doubt that someone near and dear to each one of us will need this care someday, and if you fail when you have an opportunity, are you really able to live with the consequences? This environment needs change now, and if you were to join me and see first-hand, I know you will be marching to the halls of Parliament with your strongest message to change Bill 140 immediately.

#### 1150

Many of our residents, families and staff cannot understand why this environment continues while the government made so many changes with the new beds and all of the new homes. It is frustrating for me, and sad and disappointing for them, when I have to tell them that the new Long-Term Care Homes Act provides no hope that we will be able to address these issues any time soon. In fact, with the uncertainty created by the fixed-term licensing provisions, I can’t even honestly tell them that they will ever be addressed in this home or in this community.

Our staff take little comfort for the security of their job from this either. Recently, I had a conversation with a staff member. She’s a senior registered practical nurse who asked me when and how soon any changes will occur on our dementia care home area. When informed of the uncertainty in Bill 140, she felt that staff and residents cannot continue for long in this environment.

We are seeing an increase in aggression in our residents, requiring regular high-intensity-needs funding due to their unpredictable behaviours. One factor that contributes to this increase in behaviours is the dense population, resulting in the overstimulation that occurs. It

is well known that this fact can lead to stress in persons with dementia and an escalation of unpredictable and/or undesirable behaviours. It is not an environment where efforts to implement evidence-based best practices are successful. Staff have limited space to separate residents or provide privacy within the area for one-to-one care or interventions.

This environment acts as a catalyst for staff burnout and dissatisfaction. Health human resources are one of our most precious resources in our home and indeed in Ontario, and must be protected. We need more nurses in long-term care, and actions must be taken to prevent losing them due to job uncertainties.

Any time from the day Bill 140 is passed up until three years before our licence expires, the ministry can tell us to do any one of a number of things. The problem is, none of these options works for the residents, families and staff in our home. Closing the home doesn't do it. Neither does closing some of our beds and moving them to another community, as they are clearly needed in Aurora. We are living proof that rebuilding without government as a financial partner in a capital renewal program is impossible.

With no way of knowing if our operating licence will be renewed, or for how long, it is extremely difficult, and likely impossible, that we will be able to finance millions of dollars in building upgrades. Even if we could, we would still have three- and four-bed wards and bathrooms that are not wheelchair-accessible.

I have heard comments that one of the options might be to take some three- and four-bed rooms and turn them into doubles. Without rebuilding, this measure would lead to fewer beds and, since our funding is based on occupancy, even less funding with which to finance the renovations. In addition, this would only serve to increase our waiting list, with our present occupancy level of 99% and 25 potential residents waiting for admission. Reducing our number of beds is hardly a progressive care and service option. That then presents the ministry with the option of doing nothing at all, which leaves us right where we are now.

What residents, families, staff and the community of Aurora need is reassurance from this government that homes like ours will be there for the increasing number of frail and elderly people who need long-term-care services. They also want a plan that will reassure them that government will treat them equitably and that the structure of these homes will meet their needs and expectations. I know that yesterday you heard the Ontario Long Term Care Association outline such a plan. On behalf of our residents, families, staff and our community, I urge you to give it your full consideration and support.

I cannot overemphasize the importance that, as part of this plan, government commits to move immediately to implement a capital renewal program for B and C homes. Along with the amendments and other initiatives in the solution before you, it is the difference that will make a difference.

In my 40 years of nursing, and 26 of these years as a long-term-care home administrator working in northern Ontario and throughout the province, there have been few, if any, things that would give me more satisfaction than to call a resident and family meeting to tell them that government has not only removed the uncertainty over the future of their home that has been created by Bill 140, but also that it has committed to immediately fund, develop and implement a program that will allow us to plan to eliminate the double standard in accommodation service that is a reality for them every single day. I can tell you, without reservation, they would welcome this message with enthusiasm and support. They would know that government had truly listened and responded to their concerns.

Thank you. I welcome any questions.

**The Vice-Chair:** Thank you very much for your presentation. There is no time for questions; you used all your time. Thank you again.

#### ABBNEYFIELD HOUSES SOCIETY OF CANADA

**The Vice-Chair:** Now we move to our next presentation. The last presentation for this morning's session will be by Abbeyfield Houses. Welcome. You can start whenever you're ready.

**Dr. Bob Frankford:** Good morning. My name is Bob Frankford. I'm a director of an Abbeyfield House. With me is Mr. Bob McMullan, who is the executive director of Abbeyfield Houses Society of Canada.

I'd like to thank you for the opportunity to discuss with this committee the implications that we see in regards to the Long-Term Care Homes Act, Bill 140. It doesn't directly affect us. Abbeyfield Houses Society of Canada is a registered national charity that supports a model of supportive housing in over 30 societies across Canada.

**Mr. Bob McMullan:** I've asked to chip in, I'm afraid.

First of all, in the agenda it's got "Abbey Fields" as two words. It's actually one word. It started with a road in south London, England, for which they named this society. The story I like is that the housekeeper in one of our houses had the plumber in and as the plumber left, he said, "Who do I send the bill to?" "Send it to Abbeyfield." "All right, Mr. Field, we'll see to that."

Thank you for the opportunity to participate. Although, as Bob said, we're not impacted directly by Bill 140, and although we regard it as a triumph if Abbeyfield is a resident's last address, we know that some of our residents will inevitably need to move to long-term care.

I'm now going to hand back to Bob. By the way, my name is Bob McMullan, executive director of Abbeyfield Canada.

**Dr. Frankford:** We'll be affected by this legislation not directly, but in the long run, if further legislation and regulations are introduced in regards to homes, because we are a viable, cost-effective alternative for an import-



ant section of the population. We serve many seniors who benefit from our shared family-like accommodation for 10 to 14 seniors living in a shared house designed for the purpose of providing safe accommodation, sound nutrition and a shared social environment to combat the fragility of seniors and provide for their needs.

Abbeyfield is a member of the Ontario Association of Non-Profit Homes and Services for Seniors, OANHSS, and we are aware that they have submitted a more detailed analysis of the proposed legislation. We concur with their basic concerns and have repeated them where appropriate.

I'd like to mention a summary of the issues which are of concern to Abbeyfield.

#### 1200

One is lack of support for non-profits. The McGuinty government has been a vocal champion of not-for-profit health care delivery. We are disappointed, therefore, that Bill 140 does not go further in support of the not-for-profit sector, and in fact may work to weaken this special sector. Abbeyfield relies on its volunteer boards, good people who often raise funds, and our volunteer house committees who participate to enhance the quality of life for our housemates.

For example, Bill 140 imposes personal liability on directors for failing to take all reasonable care to ensure their home meets all the requirements of the act. As well, directors could even conceivably go to jail for such a breach. We are concerned that this may present a significant barrier to recruiting and retaining directors, especially our volunteers and other directors in the not-for-profit sector.

Bill 140 will also impose harsher offence provisions on the board members of homes than on those serving on hospital boards. The Public Hospitals Act has general offence provisions, but the penalty on conviction is minor: \$50 and not more than \$1,000. A fine of \$25,000 or a 12-month jail term, as per Bill 140, is a severe deterrent to recruiting or retaining board members.

We are asking the government to include in the proposed legislation a strong and explicit statement of support for the non-profit sector, a statement that commits the province to preserving and promoting the not-for-profit delivery of long-term care in Ontario. We do not have access to the resources that a for-profit does. Abbeyfield creates social dividends, not financial ones.

On residents' rights, we support the bill's focus on residents' rights. We are concerned, however, that the proposed legislation might put homes and their residents in adversarial positions by giving individual families and residents the right to enforce individual rights even where such enforcement may infringe on the collective rights of all residents.

On the question of finance and less money available for resident care, Abbeyfield is a registered charity sponsoring over 25 Abbeyfield Houses across Canada. Although we are not a licensed care facility, the spinoffs will have an impact on retirement homes immediately and in future legislation on retirement homes. We will be

affected by this legislation because we offer support, services and accommodations to frail and lonely seniors.

Bill 140 proposes a significant increase in regulation. Long-term-care homes will have to spend a great deal more of their time and resources on compliance and administration. For example, obligations for the training and orientation of staff alone take up three full pages of Bill 140. This would be a real hardship to Abbeyfield, where each house only has one full-time staff person. Our small scale is our strength and an important and viable option within the range of accommodation and services for seniors who are not suffering from cognitive impairments.

Abbeyfield concurs that, without question, homes must be held accountable. We support measures that will enhance standards. But unless the government provides new staff funding for non-profits, and especially the Abbeyfield model, our houses may be forced to close, thus reducing the housing options for vulnerable seniors who benefit from the more cost-effective Abbeyfield model. Because Abbeyfield residents can manage outside of a more costly, medically supported alternative, meeting all the new administrative requirements of the act should not result in less money being available for seniors' needs.

Concerns about licensing: We appreciate the need for the ongoing upgrading of homes to meet the changing needs of residents, but the government cannot simply mandate this to happen by making structural compliance a condition of licence renewal. What would happen to an Abbeyfield when we have never had to be licensed? The province must establish a multi-year capital improvement program that will help homes to meet these requirements.

As well, fixed-term licensing tied to structural compliance will increase the cost of long-term financing. Lenders will likely attach a premium to cover the risk of licence non-renewals. Each Abbeyfield House has its own mortgage, so this is a very real concern and potential added cost.

**Mr. McMullan:** I'd just like to comment on the danger of overregulation for a place like ours. Around the world we have 880 houses of 10 to 14 people. We're now in 16 countries, including Japan and just recently in Mexico.

Whenever a scandal surfaces, like at a retirement home, there's a natural wish to make sure this never happens again. But overregulation can kill small houses like ours, not just by smothering them with paperwork. Some 35% of woman over the age of 65 live alone. Are they at risk? Of course they are, but risk is a fact of life. Countless numbers of caregivers are family members. Are some of them abusive? Of course they are. But regulations are not necessarily the answer.

With the Abbeyfield model, volunteers at the houses are going to see and do something about anything out of the ordinary. We've even had complaints from residents, or their family members, directed to the chairman of Abbeyfield International in England.

I'd like to comment on non-profit compared with for-profit. Studies have shown that the quality of life and the

level of care in a non-profit are usually better than one that is motivated by the bottom line. An ideal resident for the latter, the for-profit sector, would be someone who would keep quiet, often with sedation, limit calls for assistance and have an iron bladder.

Our philosophy is to remember that living like a family means getting on, but it also means not getting on. Our 9,000 residents may be very aged—the average age is now 86—but they have had interesting and fulfilling lives. They do not want to be treated like zombies.

Lastly, please help us grow Abbeyfield in Canada, a cost-effective niche for senior seniors between living independently and requiring the assistance of a long-term-care establishment or a nursing home.

Is there time for any questions?

**The Vice-Chair:** We have two minutes left. I'm wondering if each party can have a brief question, if that's possible. We'll start with the NDP.

**Ms. Martel:** Thank you for your presentation today. I see that on page 1 you said you're a model of supportive housing. Does that also mean that a number of your residents have disabilities or mental health needs that you are meeting? Is that what the reference is to supportive housing?

**Mr. McMullan:** We say it's for frail elderly, but if somebody is a bit of a wanderer and is not going to do any damage to anybody, we keep them as long as we can. Our philosophy is that if you have a very dear mother or grandmother living in your house, you're not going to send them to long-term care until you absolutely have to. That's the attitude we take.

**The Vice-Chair:** Thank you. Parliamentary assistant.

**Ms. Smith:** Just so we're clear, Abbeyfield Houses do not fall under Bill 140, right? You're not covered by—

**Mr. McMullan:** Yes, we've tried to emphasize that.

**Ms. Smith:** How many homes do you have in Ontario?

**Mr. McMullan:** In Ontario, we have four. We have another three planned or under construction.

**Ms. Smith:** That's great; we appreciate your presence in the continuum of care. I just wanted to make sure that you knew that the seniors secretariat has undertaken a review of the retirement home sector, and that would probably better qualify for you. You may want to make some submissions there as well.

**The Vice-Chair:** Thank you very much. Mr. Yakabuski.

**Mr. Yakabuski:** I've spoken to directors of some of my non-profit homes and some of them intend to resign if this bill is implemented. But I want to ask you one quick question: Given the punitive nature of the regulatory aspects of this bill and the fact that it's a one-sided situation, do you believe that without proper funding this bill will actually lead to less care for our residents, if implemented the way we see it drafted today?

**Mr. McMullan:** I think the main problem is that if we overregulate, we're going to have a problem with staffing. As you know, Abbeyfield is run entirely by 11,000 volunteers worldwide, but the staff is the house-

keeper. Now, if we overregulate, we're going to have a devil of a problem here.

**The Vice-Chair:** Thank you very much.

Ladies and gentlemen, the morning session is over. Now we are going to recess until 1 o'clock sharp.

*The committee recessed from 1210 to 1303.*

## ONTARIO INTERDISCIPLINARY COUNCIL ON AGING AND HEALTH

**The Vice-Chair:** Good afternoon, ladies and gentlemen. The afternoon session just started. Now we can start with the Ontario Interdisciplinary Council on Aging and Health. You can start whenever you're ready, sir. Please, before you start, can you state your name for Hansard.

**Dr. Larry Chambers:** Yes, I'm Larry Chambers. I'm with the Élisabeth Bruyère Research Institute. I'm the president and vice-president for research for the SCO Health Service. I have accompanying me Judy Muzzi. She'll introduce herself.

**Ms. Judy Muzzi:** Thank you. I'm Judy Muzzi. I'm with OICAH, which is the Ontario Interdisciplinary Council on Aging and Health, among other committees.

**The Vice-Chair:** The floor is yours.

**Dr. Chambers:** Honourable committee members and others, thank you for giving the Ontario Interdisciplinary Council on Aging and Health, of the Council of Ontario Universities, the opportunity to present this brief to the committee today.

A coalition of representatives from universities and community colleges across Ontario—and we've attached a list of the members—the Ontario Interdisciplinary Council on Aging and Health has as its goal the enhancement of the well-being of older persons living in Ontario through education, research and service.

The Ontario Interdisciplinary Council on Aging and Health works to promote partnerships and collaboration among universities and relevant stakeholders. It also informs and advises the Council of Ontario Universities and its affiliates on interdisciplinary issues related to aging, wellness and health.

There is a substantial increase in the number of individuals entering long-term-care homes who require complex health care. In Ontario, the 600-plus long-term-care homes employ approximately 100,000 staff members to serve 70,000 frail individuals. A project conducted in 2001 by PricewaterhouseCoopers found that over three quarters, or 77%, of the residents in long-term-care homes were women whose average age was 82.1 years, and 53% had Alzheimer's disease or some other form of dementia. The most common other diagnoses were arthritis, 30%; stroke, 22%; congestive heart failure, 11%; and diabetes, 19%.

Residents with these complex illnesses have a great need for extensive health care from physicians, nurses, pharmacists, dentists and other health practitioners. A 2005 survey of the Ontario university health sciences education programs by the Ontario Interdisciplinary Council on Aging and Health found opportunities for



education in long-term-care homes lacking in the curricula of these programs. Funded education in long-term care will overcome many of the challenges of recruitment and retention of practitioners in long-term care while making the area of study attractive to students. The development of a well-trained and committed cadre of new professionals will ultimately improve the care of seniors.

As Monique Smith, parliamentary assistant, Ontario Ministry of Health and Long-Term Care, stated in her spring 2004 report entitled *Commitment to Care: A Plan for Long-Term Care in Ontario*, "The ministry should consider how to develop better expertise in the long-term-care sector including professional development, development of protocols and standards of care, and the dissemination of knowledge and best practices to front-line staff. Several suggestions were made to us in this regard including establishing centres of excellence and pilot projects that linked an academic research centre to a LTC facility. The ministry should consider the many options available for achieving these expertise goals."

The proposed 2006 Long-Term Care Homes Act should enable selected long-term-care homes to have responsibility for the education in long-term care of physicians, nurses, pharmacists, dentists and other practitioners who are in community colleges and university health sciences programs.

One example is the Ontario Health Protection and Promotion Act of 1983, which stated in section 3 of the Ontario regulation the following:

"The minister may pay a grant to a board of health in an amount of up to 100% of the expenses incurred by a board of health in providing human and physical resources and facilities for training undergraduate and graduate students enrolled in a community college and university health science program provided that the community college and/or university enters into a written agreement with the board of health in respect of such training and the agreement is approved by the minister."

These legislative provisions enable the Ministry of Health and Long-Term Care to provide special funding to selected public health units for the support of health sciences education for practitioners to learn public health skills.

This provision in the public health service legislation led to selected public health units becoming teaching health units. These units are now part of Ontario's public health research, education and development program.

Another example is the 1990 Ontario Public Hospitals Act, which states in the Ontario regulation 964/90 that additional funding be provided to hospitals to offer opportunities for education of health professionals as well as classifying some hospitals as teaching sites.

Bill 140 assumes that there will be compliance with what is prescribed. However, what is prescribed may not lead to the intended and/or expected outcomes. In fact, completely different outcomes may result. Bill 140 should support the dedicated workers who are striving for excellence in their job performance. The bill should also

include that these dedicated workers are responsible for their actions and that they can continue to learn from experience without the fear of reprisal or punishment. Our experience has demonstrated that when staff are worried about being punished, they hide things, they are cautious and unlikely to change, they are overprotective, they do not say much, and their innovation and creative spirit is discouraged.

#### 1310

Organizations in health care and other sectors have a long history of using positive approaches for quality assurance, risk management, resident safety, as well as research, education and development. Regular and systematic reviews by peers through the Canadian Council of Health Services Accreditation is an excellent example of a positive approach to improve the structure, process and outcomes leading to quality and safety of care provided in the long-term-care homes.

The central role of positive strategies that promote organizational leadership, innovation and creativity is summarized in the following quote from Dr. Mark Poznansky, president, scientific director and CEO of the Robarts Research Institute in London, Ontario: "Health care organizations with a long tradition of excellence"—as mentioned in Monique Smith's report—"have demonstrated that research enhances the vitality of teaching, teaching lifts the standards of service and service opens new avenues of investigation."

We are fortunate in Ontario to have long-term-care homes in most communities in Ontario. They are an important community resource. Bill 140 should explicitly recognize their contribution to community life. As part of the community, they must be valued for their contributions.

Positive incentives should be incorporated into Bill 140, such as incentives for volunteering as early adopters supporting an affiliation with community colleges and universities to collaborate in education, knowledge exchange, development and/or research.

Ontario should invest in building the capacity of its long-term-care homes in collaboration with universities and community colleges, as recommended in Monique Smith's *Commitment to Care* report. The bill should include a section that ensures that there is long-term-care training in education programs that prepare new professionals as well as skills development opportunities for the continuing professional development of practitioners working in long-term-care homes.

Our recommendation to the committee for changing Bill 140 is that it should include the following section, which is worded to minimize editing in order to be inserted into the bill:

"The minister shall provide for formal agreements between long-term-care homes and universities and community colleges to jointly provide financial support for the training of health care practitioners in the care of the elderly. The Ministry of Health and Long-Term Care shall provide financial support to enable some long-term-care homes to participate in these teaching arrangements

through a funding formula outside the formula for resident care. Long-term-care homes provider and professional associations shall be invited to participate in the development and promotion of such affiliation agreements."

Thank you for giving us the time to speak.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left, and we can divide them equally. Every party, one minute only, please. We'll start with the parliamentary assistant.

**Ms. Smith:** One minute only. He's getting strict with us.

I want to thank you, Dr. Chambers, for coming. Judith, it's nice to see you again as well.

Dr. Chambers, we have in fact funded some post-secondary education and other institutes in the last two years. I actually don't have the details in front of me—I've been rustling through my papers looking—but I know that there was some funding that was provided in Waterloo to Mr. Schlegel and his group in affiliation with the University of Waterloo, to Baycrest here in Toronto, and I think to your organization, to assist in the transfer of research to learning for front-line workers. Could you perhaps just extrapolate on that for us, please?

**Dr. Chambers:** Yes. That's an excellent initiative. It's called the Ontario Seniors Health Research Transfer Network. The idea is to link practitioners, researchers and policy makers. The main focus of that initiative is knowledge exchange. We're very thankful and pleased that the ministry has provided this, and we look forward to continuing to work on that. In addition to that, we would like to more formally have the ministry support the resources required for some of the long-term-care homes in the province to be centres of excellence, as you've described.

**The Vice-Chair:** Thank you very much. Mr. Yakubuski?

**Mr. Yakubuski:** Thank you very much for joining us today and for your presentation.

We're on record as having commended Ms. Smith for her report as well, but that's when they lost us, because the report was tabled and they haven't followed through with the recommendations in the report. I'm just wondering if you can help us on that. Where did they lose it? It seems now that they've taken the political route of trying to pit themselves against long-term-care homes in this province and make them the scapegoat for what's maybe not right. If they're not going to give them the tools to operate and provide these enhancements, how can anything but failure be the result?

**Dr. Chambers:** I think that Monique Smith's report was an excellent report, and it pointed to some excellent things that should be done, including the centres of excellence. We're very optimistic that what we've presented today will be looked at carefully by this committee and recommended to the government. We also are very concerned that this act is only opened up every 10 to 15 years, and it's very incumbent on this committee to take action now because we'll be stuck with this for

quite a few years after if we don't get it right this time. That's our approach, that—

**The Vice-Chair:** Ms. Martel. Thank you very much, sir.

**Ms. Martel:** Thank you for your participation here today. Given that Ms. Smith said what she did about potential centres of excellence in the spring of 2004, are you surprised that that recommendation didn't make its way into the bill and that we have to look at an amendment that might give life to that recommendation now?

**Dr. Chambers:** I'm fully appreciative of government processes. We're here today because we think it's not too late; it's in the third reading and, again, as we understand the way this process works, this committee can intervene, as you suggest, Ms. Martel, and we would be very keen to have this committee support this. We have other presentations that are being made to the committee to allude to this same initiative. It is a theme that you'll be hearing, have heard and will be hearing more of.

**The Vice-Chair:** Thank you very much, sir, for your presentation.

ALEXANDRA SACKS

SUE FAGAN

**The Vice-Chair:** The next presentation will be by Alexandra Sacks. Welcome. You can start whenever you are ready.

**Ms. Alexandra Sacks:** I've been given a letter by a family member from the nursing home. Can I hand it in? Can I start?

**The Vice-Chair:** Sure. You can start whenever you are ready.

**Ms. Sacks:** Good afternoon, everybody. My name is Alexandra Sacks. I'm the president of the residents' council at Leisureworld, Richmond Hill location. I have been a resident here for the past three years and president of the residents' council for the last two years.

Leisureworld Richmond Hill is home to 160 residents and employs 150 staff members. As a representative of the residents at Richmond Hill, I would like to state that we support the abuse prevention and residents' rights portion of Bill 140. However, there are other areas which we do not support, and we have concerns regarding their negative impact on care and the home environment. We would like to increase the number of baths per week from two to three. But, with the increased demands for documentation outlined in this bill, this wish will not be realized. A third bath a week would improve the quality of life for all of us, but an additional bath could only be achieved by increasing the funding for staff, especially the personal support workers. Extra personal support workers would also assist in controlling other issues faced by our dedicated staff, such as improved response time to residents' requests and needs.

This bill is going to introduce more documentation to be done by the nursing staff. This is already in place in



our home, and it is easy to see that so much time is taken up by this that the residents do not get the full amount of attention required. Therefore, when we require assistance, we will have to wait quite a while before help arrives. We need extra funding for additional staff so we get the care we deserve.

Another aspect of life that does not seem to be mentioned in this bill is food. Currently, the allotment for food funding is \$5.46 per resident per day. We, the residents, have been working diligently at this home with the dietary department to achieve the best possible menu solutions with this amount of funds. However, frustration is mounting as we, the residents, want more than basic requirements. We would like to truly enjoy our meals. Some examples: We feel it is not too much to ask for salad daily. In addition, there is insufficient fresh fruit provided for each resident per day.

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Generally, the description of food on the menu and what we actually receive is quite different. The food that's presented is often disappointing. For example, it is too cold when served, and the fish is usually too thin and dry and unappetizing. To improve our enjoyment of meals, we need to have better quality of raw food purchased and more options at mealtimes. This can be achieved through increasing the food funding per resident per day. While long-term-care residents receive \$5.46 a day for food, prison inmates receive \$7.09 for food a day. Surely, we elderly deserve more.

An idea that I would suggest is for our cabinet ministers to try the \$5.46 meals for a few days. If you're wondering why I look so well-fed, that's probably because my family supplement my meals with Swiss Chalet etc., as do many other residents' families.

Another area that needs addressing is that of physiotherapy and restorative care. In our home, we originally had three days of short physiotherapy sessions, but this was cut back recently to two days because of the lack of funding. The times of the sessions are still very short, so that not every resident has an opportunity to participate.

In general, the residents of Leisureworld Richmond Hill are very happy with the range of activities and the care provided. However, there's always room for improvement.

I understand that the Ontario Long Term Care Association has given the committee a list of changes that would benefit us, the residents. It would be much appreciated if these matters could be given your serious consideration before this bill becomes law.

**The Vice-Chair:** Thank you very much. I guess we have some time, about eight minutes left. We can divide it equally among the three parties. We'll start with Mr. Yakabuski, two and a half minutes.

**Mr. Yakabuski:** Thank you very much for joining us, Ms. Sacks. I'm looking at the letter that you've brought from Florence Matta as well. She's talking about her mother, who's an Alzheimer's patient at Leisureworld, and wondering how they're going to get enough time to get exercise and all of the care that they need.

I've visited long-term-care homes in my riding and I had the opportunity to feed some of the Alzheimer's patients. That in itself can be a challenge because they're not necessarily co-operative at that or any other time, depending upon how they're feeling that day, perhaps. I'm wondering how we're going to improve the care of seniors in this province when it seems to be the approach of the government to hit nursing homes with all kinds of new demands and standards and to talk about the penalties they're going to suffer if they don't meet those standards, but not to meet the needs of those homes with regard to the funding that is necessary.

They promised \$6,000 per resident as part of their election campaign, and so far we've seen a little over \$2,000. If one third is the goal, how are we going to improve the care, which you've clearly indicated is necessary? I think we all support the spirit and the intent of the bill. The question is, how can you support the bill—not its spirit, but how can you support the bill—when you know that it is not backed up by the necessary tools to allow the people who are there on the front lines, there on the ground, charged with the job of delivering that health care to seniors? I'm just asking if you would respond to that, please.

**Ms. Sacks:** Well, I'm not terribly sure what you expect me to say, other than that the government should give more funding to the long-term-care homes.

**Mr. Yakabuski:** Now, you're a resident—

**The Vice-Chair:** Thank you, Mr. Yakabuski.

**Mr. Yakabuski:** Are we done?

**The Vice-Chair:** Yes.

**Mr. Yakabuski:** Boy, that's quick.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you, Ms. Sacks, for taking the time to come here today to make this presentation. We appreciate it.

First, with respect to the desire to have three baths a week, in fact it was a promise made by the Liberals in the last election that there would be three baths a week. I suspect that if the government actually provided the \$6,000 per resident that they also promised, you would have the staff who would be in place to allow residents to have three baths a week. One is clearly linked to the other, and the whole issue of appropriate funding really does have a direct impact on people's care.

Let me ask you about the physiotherapy services, which you mentioned have been cut back. Is this a recent development? Do you know how many of the residents were able to access this service and have now had a reduction?

**Ms. Sacks:** I can't tell you the exact numbers. I just know that going around to the physiotherapy exercises and having the physiotherapist come to see us, we are all finding that there isn't enough time for everybody to participate.

**Ms. Martel:** So the physiotherapist came to Leisureworld three times a week and is now coming twice? Is that the situation?

**Ms. Sacks:** I've come with my administrator. Perhaps she can answer that question.

**Ms. Martel:** Is that a possibility, Chair? I know it's close to being the end of time.

**The Vice-Chair:** Is anybody here? Okay, you can come forward and answer the question, if you want. Come to the mike, and please state your name before you start.

**Ms. Sue Fagan:** It's Sue Fagan. I'm the administrator at Leisureworld Richmond Hill.

What Alex is saying is that the physiotherapists were allotted so many visits per resident, and then they had to assess the residents who actually required the physiotherapy services. Then there was a cutback, and the additional visits weren't actually brought forward. They had anticipated that and had planned out their year that way, and when it was cut back, they then had to reduce the number of residents they were seeing so that they could finish their year. So it was a reduction.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** Maybe I'll just finish up with that thought. Was your Leisureworld affiliated with one of the schedule 12 physio clinics? Were you previously affiliated with one of the clinics that were providing services?

**Ms. Fagan:** We are affiliated with a service, yes.

**Ms. Smith:** Right. I think what happened, just for the information of the members of the committee, was that there were certain homes receiving a great deal of physio care and there were homes across the province that weren't receiving any, so we've gone to a system where we're allotting a certain amount per resident in all of our homes to ensure that we have more services, although some homes did receive less service because they were receiving a lot more than others. So we've gone to a bit of an equalized system.

I do want to ask, Ms. Sacks, if I could—one of the things that we've heard about from some of the operators is the increase in paperwork that they're seeing. One of the requirements in the legislation is that if you're moved to a secure unit in the home, you're entitled to rights advice. I just wondered, as a resident, if you think that is a requirement or if that is something that you would like to see happen for the residents in the home.

**Ms. Sacks:** I think it would be a good thing.

**Ms. Smith:** Also, I know that in the legislation we've got some provisions around residents' councils and family councils. Maybe you're not familiar with all of them, but we do require residents' councils, and we're looking at supporting family councils and requiring that homes, if there's not a family council, tell family members regularly that they could have one in order to try to encourage the creation of one. Do you think that those are good initiatives that will help?

**Ms. Sacks:** Very good. We've got a very good family council at our home and get a lot of attendance at the residents' council meetings.

**The Vice-Chair:** Thank you very much for your presentation.

## ADVOCACY CENTRE FOR THE ELDERLY

**The Vice-Chair:** The next presentation will be by the Advocacy Centre for the Elderly. You can start whenever you are ready.

**Ms. Jane Meadus:** Thank you. My name is Jane Meadus and I'm a lawyer with the Advocacy Centre for the Elderly. I'm the institutional advocate, which means that my job consists of representing clients who are in long-term-care homes. I'm here today with my executive director, Judith Wahl, and Pauline Rosenbaum, another lawyer who helped—we all helped write the brief which is in front of you. I just wanted to thank you for seeing us today and letting us have a few minutes to provide some information to you.

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We're generally in support of the legislation. It's too bad that the hearings have been shortened, because this is a very, very important piece of legislation. I think there are a lot of groups that are missing, and it's too bad that there's not more representation from the actual residents of the homes. I was very pleased to hear the resident we just heard from.

My comments today are going to be focused on the issue of the detention and restraint of long-term-care residents. We know that many of the speakers have not been supportive of rights in long-term-care homes with respect to admission to the secure units and restraint issues and we want to say that we're fully supportive of that. There's an appendix to your material that we've actually written, a lengthy section that we think should be put into the Health Care Consent Act, but I want to put it in terms that you can understand: people oriented.

With respect to the general restraint issue, it comes up a lot, and just so you know, about a third of the clientele at our office are from long-term care. One of the issues that we get all the time is what I call our Tim Hortons problem, which is the senior who wants to go down to the local Tim Hortons for a cup of coffee and is prevented from leaving the facility because of environmental restraints, because the facility has a policy that no resident may leave the facility without an escort, or perhaps the daughter of someone says, "Oh, I don't want her to go out. She might fall down," even though that resident is competent. It has always been our position that these environmental restraints have been illegal, but at the moment there's no way for the person to challenge that restraint, nor is there any way of the facility knowing that there's a process on how to do it properly. We have asked that any kind of restraint be included under the HCCA treatment section so that it gives a person rights under that section.

The more important issue is secure unit detention. I'm going to tell you the story of Sandy Shook. Ms. Shook is sitting here in the front row. Sandy, do you want to wave? Sandy is here today at our request. When she was 51 years old, she was placed into a locked unit in a long-term-care facility. She did not at that time meet the criteria under the Mental Health Act, so she was not held



in a secure unit in a psychiatric facility. She does suffer from a bipolar disorder, as well as physical issues, and was placed in that unit by her power of attorney for personal care. She began complaining to get out of that unit and there was no process there. It wasn't until about 2002 that she started really being able to reach out into the community. So it was from 1997 to 2002 that she was in locked units. She was told she was not allowed to leave the locked unit. She was actually being kept there by what was really her guardian of property, who had no authority to keep her there.

Once she transferred to a new facility, things got worse. They would let her out for one or two outings a week to programs that she was taking in the community, but if she wanted to go out and visit her children, who lived in the community, or go to an art show or something like that, she was prevented from doing that. She was followed if she did get out of the facility on one of her infrequent outings. She would have been followed if she was going to the store. The staff there followed her. She was basically told she wasn't allowed out. It wasn't until the end of 2004 that she was able to contact our office. She was only lucky in doing that because she actually had a phone. Most people in locked units do not have a telephone. They have to use the telephone at the front desk. Because there isn't any information, there's no understanding of the fact that these are locked units. She was actually very lucky in being able to get someone. Most people in those units can't access anyone.

If you've ever been in a locked unit in a long-term-care facility, you've had people coming up to you all the time saying, "Help me. Help me get out," and you're told just to ignore those people. There are usually signs around saying, "Do not let Mr. and Mrs. So-and-so out." There is no authority at the present time for those facilities to do that. There are lots of people in there who shouldn't be locked up. These units should be used for preventing people with dementia from wandering, but that's not what happened in our case and it's not what happened in many of our cases, in fact. These units are used sort of as a quasi mental health ward because people are being downloaded out of mental health facilities into long-term-care homes. Many of the groups that have come before you have said that having rights advice and all these sorts of protection is going to be burdensome on them and difficult to manage. But just imagine that it was you who were kept against your will. As I said, Ms. Shook was 51 years old when this happened to her.

In Canada we have the charter. We have other rules that say you cannot be detained against your will unless it's done in accordance with the law, which includes the charter. We've set that out for you in our presentation.

We think the issue of emergency beds and emergency placements is a bit of a red herring, because there's rarely a bed. Secondly, the purpose isn't to deal with these emergency situations. We do have the Mental Health Act if the person really needs to be locked up and to prevent them from harming other people. There are specific issues. You can also look at the Casa Verde Elroubi

inquest materials, the recommendations for the types of things they were dealing with and suggestions they had to deal with some of these people.

We also want to address very quickly that we've heard lots of complaints that there are going to be too many rules dealing with this legislation. We can tell you that we do get a lot of complaints from long-term care. At present there are many laws which deal with long-term care, such as the Health Care Consent Act and the Personal Health Information Protection Act. They're not being complied with but they're also not being enforced. We're hoping that this legislation will help to enforce them.

The last point that I want to make is that we're asking that there not be any exemptions from the annual inspections for this reason. There are too many variables in long-term care that change. One home can be very good one year and very poor the next year, and vice versa, so we would ask that you don't change that part of the legislation. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left, which we can divide equally among the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for the presentation today and for the extensive brief for the committee members. You're quite correct that we have heard from a number of people, with respect to rights advisers, making the argument that there are emergencies, and by the time you contact a rights adviser and the adviser comes and provides advice, you may have a serious incident on your hands. There was also some suggestion that one compromise might be to set a time limit within which a rights adviser would have to provide advice to either the resident or a substitute decision-maker. I don't know what your thoughts are on the second one, some kind of time limit around the provision of that advice, or if the view really is—I haven't read the whole brief, so I apologize for that—that in all circumstances with respect to secure units, rights advisers have to be given that opportunity and there shouldn't be a limit on the time. It's as soon as they can get to it, and that's what happens.

**Ms. Meadus:** In fact, the brief that we have, the appendix that we put in, which is a whole new section to the Health Care Consent Act, actually deals with those kinds of emergency situations. In the mental health area, it's of course done through the Psychiatric Patient Advocate Office, whom you heard from yesterday. They're actually very quick at coming out, and it's sort of forthwith, so it's generally a very quick process. It'll obviously be a little longer because they're not going to be in-house here.

We actually put in an emergency provision in the sections we had, saying that rights advice could in fact occur after, so if it were that kind of emergency situation, you could place, and then the person could have rights advice and potentially have a hearing. Then, if it was found that they didn't need to be there or whatever, they could go back into the regular population.

**The Vice-Chair:** The parliamentary assistant.

**Ms. Smith:** I note that in your submissions there are a number of recommendations. One of them was to include in the bill of rights a right to have a friend or an advocate of her own choosing attend any meeting. Why would you be requesting that that right be included?

**Ms. Meadus:** This has come about through our practice. We've had many clients in many homes tell us that we are not allowed to go to meetings with our clients in the homes. This is generally where there's an issue that the person is having problems with the home. Maybe they've been making complaints, and it may be a special meeting or an annual meeting. The facility will likely have nine or 10 people—administrators, nursing assistants, nurses, doctors etc.—at the meeting and perhaps only the resident or the resident's substitute decision-maker, which can be extremely overwhelming. But they're in fact told point-blank, "You are not allowed to bring anyone to a meeting." We think that they have a right to have someone there for support, someone who may be a little bit more knowledgeable about the process and what should be occurring to help them advocate on behalf of whatever the issue is that they have.

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**Ms. Smith:** You also, in one of your sections, are requesting that inspectors be able to enter homes without a warrant in emergency situations. Have you ever had a situation or are you familiar with a situation where an inspector hasn't been able to enter a home?

**Ms. Meadus:** Not to my knowledge, but we thought that was important.

**The Vice-Chair:** Thank you very much. Mr. Yakabuski.

**Mr. Yakabuski:** Thank you very much for joining us, and thank you to Sandy for joining us as well.

You talked about patients with mental health issues being downloaded into long-term-care centres. We're seeing that patients from developmental services homes, such as Rideau Regional Centre or Huronia—that's happening right now.

I certainly support what you're talking about, that we have to protect people who are being held against their will. But when we're giving the people in long-term-care centres these kinds of additional challenges—because I think it's safe to surmise that perhaps those people with mental health issues are going to require a higher level of care than someone who does not have any. So we're giving all our health care workers in these homes more and more challenges and higher expectations with regard to the tasks that they must carry through, yet I see nothing from this government in this bill that is going to assist them from a financial point of view in making this happen.

Do you have an opinion on this bill, having looked at it not only from your own perspective but from the broad perspective of how it affects everybody, as to whether or not the laudable goal of this bill could in fact, as some people have said—that the result could be the exact

opposite, which is a reduction of the actual level of care for the most vulnerable people in our society?

**Ms. Meadus:** Our position is that this bill can't go ahead without additional funding. It has to have the funding to support it. As you pointed out, we're getting a different kind of clientele in the long-term-care homes. You're getting a lot more people with mental health issues, a lot of younger people, a lot of people with developmental issues. The staff have to be properly trained for that. That's very different from people who have Alzheimer's or other related dementias or are simply frail. The bill, quite frankly, I don't think will work without the funding in place. We're not supportive necessarily of certain numbers of hours or anything like that, because we want the care to be specific to the residents. But that has to go hand in hand with the appropriate funding.

**The Vice-Chair:** Thank you very much for your presentation.

## CANADIAN AUTO WORKERS

**The Vice-Chair:** The next presentation will be by the Canadian Auto Workers. Welcome.

**Mr. Corey Vermeij:** Thank you. My name is Corey Vermeij. I'm presenting on behalf of the Canadian Auto Workers, and Darlene Prouse is at my side. Darlene is the elected president of the Ontario Health Care Council, representing the CAW members working in particularly long-term-care facilities but generally in the health sector.

As our submission is being passed out to the committee, I want to welcome this opportunity to consult on this very important piece of legislation. Long-term-care reform has been a long-awaited effort. It obviously requires the collaboration of all advocates for quality care for our elderly, and I know that there are certainly advocates at this table and in this room. The government is to be commended for bringing this bill forward, and we acknowledge the work of the parliamentary assistant in her efforts as well in terms of the commitment to care and the broad overview and that this legislation has many important elements that reflect the government's agenda but also sets aside other key initiatives that have had a significant impact in long-term care.

Having said that, we want to use our allotted time to press home on the policy argument in terms of a minimum staffing standard. We see a minimum staffing standard as absolutely critical to any real, meaningful reform in long-term care. We want to review it in two parts: first of all, the support for the principle of a minimum standard and, secondly, what an appropriate number would be to attach to a minimum standard for Ontario.

We certainly acknowledge that there has been considerable work making improvement in a system that had been allowed to deregulate or allow market forces to govern in terms of the care. The abandonment of the minimum staffing standard in 1995 saw care levels plummet, and as a result the Legislature, when it was



presented with a resolution in November 2002 by Lyn McLeod, supported that resolution. To quote the first page of our submission, in her concluding remarks after that debate in the Legislature, Lyn McLeod stated, "Minimum standards are not adequate quality of care. I would never argue that for one moment." She concludes by stating, "Minimum standards are at least a way of holding a government that does not care to a very basic minimum standard." We would certainly trust that all governments should be held to a minimum standard as basic as one in terms of the level of care to our most frail and vulnerable seniors.

More recently, the Minister of Health has indicated, in introducing this proposed bill to the Legislature, that it is the cornerstone of the government's strategy to ensure the best possible level of care and that it is intended to make Ontario a leader. That is a challenge that we wish to join the government of the day in pursuing. We want the best possible level of care. We want Ontario to be the best amongst comparable jurisdictions. We think the most pressing means by which we reach that end is a minimum staffing standard.

The first piece, in terms of the actual drafting of the proposed legislation: We think the fundamental principle recorded in the bill at section 1 needs to be significantly revamped to reflect not just that long-term-care homes are homes—they are, indeed—or that residents are entitled to dignity, security and comfort, but that some very fundamental aspects are taking place there. One is that it is a site where skilled nursing and personal care is being provided to residents—it's more than simply a home; few of us have those services available in our home—and, secondly, that the goal is the highest possible or practicable level of well-being for residents, that there is something beyond just comfort and security that we hold ourselves to.

Ontario has always had a minimum standard, until 1995, since the Nursing Homes Act was introduced. It has evolved over time. It started, as I understood, at 1.75 and evolved to 2.25. When it was abandoned, the results were predictable. According to Statistics Canada, the levels of care plummeted from levels generally at or above that minimum standard to levels below it, and at the same time, as we know, the acuity of residents, the provincial case mix measure, was increasing steadily and significantly. So you had the perfect storm: falling care levels, rising resident acuity. The difficulties that ensued in terms of Natalie Babineau or Casa Verde were almost predictable in that perfect storm.

Ontario continues to regulate other elements of staffing, and we show that at table 1: a range of administrator, director of nursing, registered nurse staff, the food service supervisors and handlers and various activation and therapy services, as well as a registered dietitian. So it's not that Ontario is averse to minimum staffing standards; it's whether there's a broad, encompassing standard that will measure the bulk of time that is provided to residents on a daily basis for their nursing and personal care. Secondly, Ontario has con-

siderable minimum standards in other aspects of regulation in terms of the size of the bedroom, the width of a corridor, the amount of food that is daily dispensed, and in what portions, to residents.

**1350**

We would also emphasize again the coroner's inquest recommendation, the jury recommendation in Casa Verde that calls specifically for minimum staffing standards.

Finally, in terms of being the best jurisdiction, we have compared Ontario to its neighbours around the Great Lakes. Of the eight US states around the Great Lakes, as we show on table 2, all but New York state have a minimum staffing standard. All have, in consequence, average hours per resident per day well in excess of three—the lowest is 3.3 hours per day and the high is 3.9, specifically in Ohio and Pennsylvania. These are states with significant populations in nursing home facilities. The last column is their ranking in terms of 50 states, where they rank in terms of their population within a nursing home facility. So they are very telling comparators. Just as a side note, only one of those states has a 24/7 RN staffing standard, but all but one have other regulation directed to direct care and registered nursing staffing.

So the operators that are for-profit and operate south of the border, like Extendicare—roughly 75% of its operations are in Ohio and Pennsylvania—know this regime well. They know how to operate their business with a minimum staffing standard. It doesn't behoove them to come to Ontario and say, "We cannot live with a minimum staffing standard," when their operations in the US do.

Similarly, we're cognizant of the fact that in Ontario municipal homes for the aged, municipalities are subsidizing the levels of care, have maintained their hours of care consciously. But it shouldn't be the wealth of one's community that determines the level of care for residents in Ontario. It should be a provincial obligation to ensure that across Ontario residents are provided at least a minimum standard.

We also want to speak to the research in regard to the evidence in terms of continuity of care and the quality of care. Obviously, the envelope system in Ontario has leakage. Only \$4.17 of a \$6.33 per diem increase flowed to staffing salary and wage costs. Other portions flowed elsewhere. The envelope system, in and of itself, will not necessarily be a dollar-for-dollar means by which we can increase staffing levels. There will always be some offsets there.

At the same time, we also want to note that particularly for-profit operators instantaneously seem to wish to readjust their staffing levels when CMM and CMI results are known to them. After the release in December, Extendicare, in one facility, immediately corresponded with our union and said, "Our CMI has just dropped from 100.77 to 99.88"—less than a 1% decrease—"and we're going to therefore give you notice that layoffs and reduction in hours are necessary." At the same time, they

were aware that the provincial CMM increased by 3.15, an offset more than sufficient for their 1% decline. But the staffing levels are adjusted that quickly and that specifically to resident acuity fluctuation.

The last pieces I wish to speak to are simply that a minimum staffing level will ensure that the risk to health and safety of residents and the care providers, the workers, is reduced. There is considerable evidence in that regard in terms of injury rates, infection etc.

Finally, it is about accountability. We appreciate that it has a significant element of funding, but it is about accountability of government and providers to the residents and to the public in Ontario that they are committed to and providing quality care.

**Ms. Darlene Prouse:** We would also like to see that we achieve that minimum nursing staffing standard averaging 3.5 hours. We submit that the fundamental purpose of reinstating a minimum staffing standard is to ensure the level of care provided each individual in a long-term-care home does not place the resident at risk of poor care outcomes. While every staffing standard is expressed as a quantity or a number to have operational relevance, the standard ought to be inherently dynamic and variable based on resident acuity. The staffing standard must be an aggregate measure, a reflection or composite of numerous individual care requirements or needs such that it provides a minimum guarantee that each individual resident will receive not less than the minimum standard in care on average over the relevant reporting period. To be relevant, the minimum must be expressed relative to the case mix index.

Some of the averages in other comparable jurisdictions are:

—3.7 hours was the average in all certified nursing home facilities in the US in 2005;

—3.63 hours was the average nursing hours per day in eight neighbouring states bordering the Great Lakes with Ontario in 2005, ranging from 3.3 to 3.9.

The 1995 Nursing and Personal Care Provider Study—over a decade ago—found, prior to the elimination of the minimum staffing standard, that long-term-care residents were receiving about 140 minutes, or 2.33 hours per day, including indirect, non-nursing time, or about 21 minutes of direct care on an average shift. This study was intended to empirically develop the resource-use weights for the new levels of care categories being implemented under the CMI system.

The subsequent 2001 study reported staffing levels in Ontario at 2.04 hours per day and highlighted the existence of considerably higher average staffing levels in other, presumably comparable, jurisdictions—other Canadian provinces, US states or countries. The study noted that 34 of 50 states in the US in 2003 had average nursing staff hours per day in nursing home facilities of 3.5 hours or more, and all 50 states were providing for greater than three hours. At the same time, the report noted that Ontario ranked higher on measures of resident acuity or assessed needs than many of these same jurisdictions.

The 2001 report to Congress identified distinct minimum staffing standards: an absolute minimum staffing threshold of 2.95 hours per day applicable to all residents and a preferred minimum staffing standard of 3.45 hours per day, subject to resident case mix or acuity. The absolute minimum is a threshold below which the association with quality problems was compelling; it placed residents at considerable risk of poor-quality outcomes. The latter standard of 3.45 hours was cited as the preferred minimum level at or above which residents were not at increased risk—

**The Vice-Chair:** You have one minute left.

**Mr. Vermey:** We've also provided detail in terms of the jurisdictions where we can obtain information on their current staffing levels or their targets for the Ministries of Health in those jurisdictions. You'll see that Alberta is similar to Ontario—the Auditor General's reports on the system, an obvious flashpoint—and have committed now to fund at 3.6. In Manitoba the actual is at 3.3. New Brunswick, after the election there, is moving to 3.5 on a funding level; this is not a minimum standard but a funding level. Nova Scotia is at 3.25.

What's compelling is that the role of long-term care is evolving at all times. We know that Alzheimer's and other forms of dementia are a higher percentage of the population. We know that palliative care is increasingly important in long-term care. There have been a number of studies of palliative care in Ontario facilities. Directors of nursing have been surveyed; care providers have been surveyed. They conclude that staffing is inadequate. They had a particularly poignant quote from a respondent: "We've barely enough staff to provide care for the living.... We don't have the staff to provide the proper care for the dying."

Certainly in the last year, months, days of life, we as a province must do the best we can possibly do for these residents. Nursing homes are increasingly sites that must have adequate palliative care for residents.

**The Vice-Chair:** Thank you very much for your presentation. There's no time left for questions. Thank you again.

1400

## ONTARIO NURSES' ASSOCIATION

**The Vice-Chair:** Now we move to our next presentation, the Ontario Nurses' Association. They can come forward if they are ready. Welcome.

**Ms. Linda Haslam-Stroud:** Hi. Thank you.

**The Vice-Chair:** I guess you know the procedure. You've been here many different times, so it is familiar.

**Ms. Haslam-Stroud:** Yes, and I've met you many times here too.

**The Vice-Chair:** I would ask you, if you don't mind, to state the names of your colleagues.

**Ms. Haslam-Stroud:** Yes, I will. Good afternoon. My name is Linda Haslam-Stroud. I am a registered nurse and I'm president of the Ontario Nurses' Association, ONA. With me today are Bev Mathers and Lawrence



Walter, two of my colleagues who work very closely with long-term-care nurses in Ontario.

I am speaking on behalf of 52,000 front-line registered nurses and allied health professionals whom we represent. Those also include registered practical nurses, PSWs and social workers. All of these members deliver care to Ontarians. Included in those are 3,000 registered nurses in long-term-care facilities.

ONA has been advocating for an improved long-term-care system for many years. Our submission has a number of recommendations. The only one I'm going to speak of today is in relation to minimum staffing levels. I know it seems to be a new topic and you haven't heard anything about it in the last two days. That will be my priority.

The other two priorities that I just wanted to point out to you that I'm not speaking of are whistle-blowing protection for workers and also the transparency in the inspection process.

I'm going to now move to the whole issue of minimum staffing standards.

We made 52 recommendations that were adopted by the April 2005 coroner's jury for the homicide at Casa Verde nursing home.

A key coroner recommendation directed the government to fund staffing standards in nursing homes. More than a year later, the Ministry of Health and Long-Term Care has yet to implement these important staffing measures that we believe would prevent a similar tragedy.

Many of the residents in long-term care are in need of complex nursing care, and you've heard that. I was trying to relate it to my nursing life. In 1977, I was a nurse at St. Joe's hospital in Hamilton as a new graduate. The complex patients we took care of—the elderly in the hospitals—are no longer there, generally; they are now in long-term-care facilities. That's when we talk about the acuity and complexity. That role for the caregivers in Ontario has transferred over to these very long-term-care facilities that we're talking about today. Our members continually tell me that our long-term-care residents require the broader assessment skill set that registered nurses bring because of that type of acuity. Those are both physical assessments and also from the cognitive care perspective.

Bill 140, however, is missing key elements that are essential to safe long-term-care home environments. Today, we comment on the need for evidence-based staffing standards and levels of resident care. While the focus of Bill 140 is on resident safety, we also believe that safety and working conditions are equally important for us to actually provide that quality care.

ONA believes the government should also be concerned about recruitment and retention issues in long-term care, particularly in light of the coming wave of RN retirements. While ONA recognizes that the government has invested more funding in long-term care, we believe that enhanced transparency and accountability are needed to ensure that public funding is properly targeted for resident care.

And at the same time, the care needs of residents living in long-term-care facilities in Ontario have increased. Their conditions have become less stable and more complex, as I was speaking about just a few minutes ago. Nursing and personal care staffing, however, haven't kept up with those increases in resident acuity, in part, we believe, because of the elimination of minimum staffing standards. I believe that was in 1996 under the previous government.

Bill 140 does not reinstate minimum hours of care that residents will receive, and we believe there are no assurances then that our residents will receive the level of care they need. There is no fundamental principle clearly setting out that residents have the right to access the care they need. There is not even a statutory requirement that the long-term-care home have sufficient staff to meet its statutory obligations.

This omission is very perplexing to us as nurses across Ontario because the government is well aware of recommendations from Casa Verde. Three key recommendations in that inquest actually related to establishing minimum standards and levels of care. Recommendation 28 directed the Ministry of Health and Long-Term Care to have an evidence-based study conducted to determine appropriate staffing levels for Ontario, given the significant number of Ontario residents with cognitive impairment and complex care. That was a key priority.

Recommendation 30 directed the Ministry of Health to set out standards, based on study findings, to ensure that residents are given appropriate nursing and other staff care hours. I'm sure you've been told this already but I would like to identify it to you again: There is no requirement in Bill 140 for an evidence-based study to determine the hours of care for residents with different acuity levels.

Another recommendation in the Casa Verde inquest—it was number 29—actually directed the ministry in the interim when this report came out, pending this evidence-based study that I've mentioned, to fund and increase staffing levels to no less than 0.59 RN hours per resident per day. That may be different from some of the previous submissions that you've heard in relation to total hours. This inquest actually looked at the issue of RNs and identified 0.59 RN hours per resident per day and 3.06 hours of nursing and personal care per resident per day overall.

The government has stated that some residents in long-term care do not require the coroner's recommended interim minimum staffing, but to date, we haven't really seen the evidence to support that assertion, so we'd be interested in having some more discussion on that. On the contrary, we believe that there is evidence from other jurisdictions in Canada that are moving to higher levels of staffing and care for residents; I think some of the previous speakers have highlighted some. I'll point out two, Manitoba and Saskatchewan. They provide over three hours of care per resident per day. In Alberta, they have funded paid hours of care per resident at 3.6 hours

per day. Another one is New Brunswick, which is moving to 3.5 hours of care by 2008.

In the United States, 16 experts have reviewed previous studies on staffing for quality of care, and they have concluded that to improve the quality of care of nursing home residents, staffing levels should be increased to 4.55 hours per resident per day, including 1.15 RN hours per resident per day. In Ontario, by comparison, the Ontario Long Term Care Association reports that its members' homes provide on average 2.5 to 2.6 hours per resident per day, although I understand the government is indicating that it is slightly higher than that.

No matter whether it's 2.5 or slightly higher, that is not enough to provide the quality care that our residents deserve. And given the increased acuity levels, much higher care levels per resident per day are required. Moreover, the proportion of total care provided by RNs is actually decreasing.

The 2004 Provincial Auditor's report also made two staffing recommendations to the ministry. The first one was to track staff-to-resident ratios, the number of registered nursing hours per resident and the mix of registered to non-registered nursing staff, and to determine whether the levels of care provided are meeting the needs of our residents. The second recommendation from the auditor's report was to develop appropriate staffing standards for long-term-care facilities.

Clearly, the auditor was concerned that in order to meet resident care needs, the Ministry of Health had to determine whether the needs were being met and then to adopt appropriate levels. Bill 140 will not improve the levels of care that residents receive on a daily basis unless this bill mandates staffing standards and levels of care.

Therefore, we are recommending—no surprise—that Bill 140 be amended to reinstate minimum staffing standards of 3.5 hours, including 0.68 RN hours. That would bring Ontario in line with staffing standards in other jurisdictions. The number of hours for RN care and other staff could be determined by regulation. In addition, the government must implement the coroner's recommendation for the evidence-based study that I referred to to determine the appropriate levels.

I want to conclude by talking about RN care. The requirement in subsection 7(3) to have at least one RN on duty and present in the home at all times, although an excellent principle, does not actually guarantee residents will have a greater amount of RN care. It does not guarantee that each resident will be assessed by an RN. It does not guarantee that each resident will even be given the smallest amount of RN care. The only way to guarantee resident hours of care is to set and to fund minimum hours of care, including minimum standards for the RN component.

I want to talk a little bit about the assessments that we do with our residents in long-term care, assessments of the resident's functional capacity and behaviour. Section 41 provides that assessments can be carried out by

professionals other than physicians or registered nurses, and this has caused us some concern. If the initial assessments of residents coming into long-term care are not carried out by the highly skilled professionals we have before us, we are concerned that we are then not being proactive in trying to prevent further illness of our elderly. At the end of the day, if we proactively assessed our residents with the highest skill level that we have available to us in our homes, we actually could be saving the health care system money by preventing readmissions to acute care facilities and increased complexities of diseases that could have been prevented.

1410

In relation to the initial assessments of residents, we would support adding to the proviso regarding the residents' assessments to ensure that situations like the Casa Verde never happen again. Therefore, we recommend initial resident assessments and the ongoing assessments are conducted by RNs. I've explained to you why I believe that's a proactive measure for health and for the financial stability of the system.

In summary, residents of long-term care receive their care from a great component of skilled front-line workers. However, we believe that this bill has chosen to ignore the care requirements of residents by failing to include evidence-based or even interim minimum standards for staffing and levels of care in Bill 140. We believe this is the fatal flaw in the bill and it must be addressed.

As I mentioned, we have provided 38 other recommendations for amendments to the bill in our submission. We, as the nurses of Ontario and the allied health professionals of Ontario, who work each and every day with our elderly residents of Ontario, request that these recommendations be given serious consideration by your committee so that our residents in long-term care will receive the care they deserve. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left, which we can divide equally among the three parties. We'll start with the parliamentary assistant. You have one minute.

**Ms. Smith:** On your assessment requirement, under subsections 41(4) and (5), we require that the original assessment of the physical and mental health of the applicant be done by a physician or a registered nurse, and that,

"An assessment of the applicant's,

"i. functional capacity,

"ii. requirements for personal care,

"iii. current behaviour, and

"iv. behaviour during the year...." be done by an employee or agent of the placement coordinator, who is more than likely a nurse, because the placement coordinator is usually through the CCAC—sorry, we also require that it be a nurse or a social worker. Are you saying that you don't think social workers or doctors should be involved in the assessment of these residents prior to their placement?



**Ms. Haslam-Stroud:** The fact is that physicians aren't usually part of the component of that initial assessment that we're filling out. Social workers have a broad base of knowledge, certainly with the cognitively impaired component of the elderly, but they do not have that higher-level-of-assessment critical thinking skills in relation to the physical assessment of these patients. So our proposal regarding RNs is very specific to the fact that we, as RNs, hold both those components of assessment skills.

**The Vice-Chair:** Thank you very much.

**Ms. Smith:** Can I just ask one more? The 0.59 RN: Is that "RN" as in "RPN"?

**Ms. Haslam-Stroud:** No. That's "registered nurse."

**The Vice-Chair:** Thank you very much, Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Linda. It's very interesting, when presentations have been made, to hear that the Americans seem to be allowing for a greater number of hours of care than we currently are doing in Ontario. That was held up to us yesterday and today.

But I want to ask a question about the issue of abuse. If someone is found guilty of abusing a resident, there's been some concern expressed about the individual being reinstated. We've been asked to include an amendment that an individual, an employee, found guilty of abuse not be reinstated and not be allowed to work in that long-term-care home again. What would be your position on that issue?

**Ms. Haslam-Stroud:** Since we do represent the majority of registered nurses, we're under the college standards. So the reality is that if we are not registered with the college because of a separate regulatory body removing our registration, we wouldn't even be in the capacity, I don't believe, Mrs. Witmer, to actually provide the care because we would not have our licence. That, of course, is up to the regulatory body.

**Mrs. Witmer:** That's right. So once it's gone, you wouldn't qualify to work in that home again.

**Ms. Haslam-Stroud:** As a registered nurse, no.

**The Vice-Chair:** Thank you, Ms. Martel.

**Ms. Martel:** Thank you for your presentation today, and for ONA's participation at Casa Verde during the whole inquest. It was very important.

I've been focusing on minimum standards and the need to reinstate them, especially given the government's promise during the last election to reinstate them. I think it should be 3.5 because of increased acuity. From your perspective, even though you've provided lots of evidence of other jurisdictions, just on a practical level, why do you have to have something regulated, why do you have to have something legislated, in this case in order to meet the needs of these residents?

**Ms. Haslam-Stroud:** When we look at where the money is invested in long-term care—and there are some different pots that have to be reimbursed to the government if they are not spent. But the reality is that with the financial challenges, we believe, of long-term-care homes, as the complexity of the resident increases, the money is being stretched. We as the front-line

caregivers, and, frankly, the registered nurses and patient advocates, know that when we go into that facility, we are not even providing the basic quality that these residents deserve. So if it's down to the point where we're fighting about where the dollars are going to go, if the employers and the facilities have a mandate to meet those standards of care—and that was in my speech—we can give them the capacity to have a framework to work from. Otherwise, if you look at all the facilities across the province, it's all over the map.

**The Vice-Chair:** Thank you for your presentation.

**Ms. Haslam-Stroud:** Thank you.

#### CARP, CANADA'S ASSOCIATION FOR THE FIFTY-PLUS

**The Vice-Chair:** The next presentation will be by CARP, Canada's Association for the Fifty-Plus. Welcome back. You can start whenever you are ready.

**Mr. Bill Gleberzon:** I want to thank the committee for this opportunity to make a presentation. Rather than describe CARP, I'll just say we represent consumers, families, children, spouses etc., and that's the point of view we're bringing in our presentation. In general, we congratulate the Ministry of Health for producing a comprehensive and integrated act. Obviously, a great deal of thought has gone into developing Bill 140. In particular, CARP lauds its primary and principal focus on resident-centred care in long-term-care homes.

CARP has heard from some that the act may be overly prescriptive and leans towards micromanagement by the government. However, we do not find that to be the case in our reading of the bill. Moreover, given the particular vulnerability of the seniors who inhabit long-term-care homes, the breadth and depth of the bill is a very good thing. Having said that, we have some concerns, and you've heard some of them from other organizations that have made presentations.

Adequate additional funding must be forthcoming from the ministry in order to enable long-term-care homes to comply with all the directives in the bill; for example, if hiring more staff for this purpose is necessary.

You've heard quite a bit about hours of daily care, and we want to add our voice to that issue. We applaud the ministry for increasing the hours of daily care from 2.25 to 2.5. However, 2.5 hours is still below the standard of daily care in other provinces of 3 to 3.5 hours. So we urge the ministry to phase in additional hours of care, from 2.5 hours to 3 hours to 3.5 hours and more, where needed, beginning immediately, and completely implement it within a year.

Personal hygiene: There's no reference to personal hygiene in the care and services section. While the new policy that mandates two baths per week is an increase of 100% over the previous policy, that is still not adequate hygiene, particularly for people who are incontinent. Those with incontinence problems should receive as many baths, or at least sponge baths, per week as they

require in order to maintain their comfort and dignity. We recognize that providing more baths may necessitate more staff. Well, if that's the case, then so be it.

The well-being of the residents must be the paramount consideration. In addition, the bill should be amended to include the provision of dental care for residents.

All long-term-care homes must provide foot care, through podiatrists, for residents as needed. As you know, many older people have particular problems with their feet.

1420

Subsection 10(2) states, "Every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied." However, we are concerned that allocating just over \$5 per day per resident for food seems inadequate to meet this directive, even with the most frugal bulk buying; in fact, it's about \$2 less per day than the amount allocated for those who are incarcerated in jails and prisons. Even taking into account the difference in caloric intake between the two groups, a review of the adequacy of funding to meet the nutritional needs of residents is required.

Nor does the bill take into account the fact that Ontario has two primary seasons, one that requires heat and the other that necessitates air conditioning. Also, long-term-care homes must be prepared for the climate change that is occurring in Ontario, across Canada and the world. Bill 140 does not mandate that air conditioning must be available in each long-term-care home to service the health and comfort needs of residents and staff. We think that is an oversight that should be rectified.

Sections 67, 156 and 177 impose personal liability on all members of the board of directors of a home if they are found guilty of failing to ensure that their long-term-care home meets all the requirements of the act. In such cases, each director, individually and collectively, could face heavy fines up to \$50,000 and 12 months in jail. This personal accountability could prevent individuals from volunteering to serve on boards. CARP recommends that the ministry provide sufficient funding for each long-term-care home to enable the purchase of adequate officers' and directors' liability insurance. Just in passing, I point out that this is a concern in any kind of volunteer agency. It's something that the province should be looking at regardless of what that agency is.

Subsection 74(6) talks about training for all staff, particularly direct care staff. We think that training must include geriatrics, because they must know at least the basics about the people they're serving.

There is a dire need to address the shortage of staff, as you've heard from the other presenters, in long-term-care homes—in fact, in the health care system generally—and in particular, direct care staff in long-term-care homes. Although we're not taking about home care, the same is true about personal service workers.

CARP recommends that the Ministry of Health and Long-Term Care, in collaboration with the Ministry of Education, establish special grants to pay for the cost of

the high standard education in post-secondary institutions for those individuals who want to train in this profession. Our experience is—and we hear from a lot of people who are direct care workers or professional service workers—that they pay on their own for the training, and then they find, if they do get jobs, that the jobs are inadequate in relation to the amount they pay.

Finally, there are some endorsements that CARP would like to make. We support the Ontario branch of the Canadian Legion's recommendation that the ministry establish an arm's-length ombudsman to whom seniors and their families can turn in regard to long-term-care issues in general, including long-term-care homes. It is very important that such a position be established and that that position be absolutely independent, perhaps responsible directly to the Legislature to ensure that independence.

CARP also endorses all of the observations and recommendations expressed in the Advocacy Centre for the Elderly, ACE, response to Bill 140. That document is attached. I know you heard from ACE earlier this afternoon, so there's no need, and I had no intention, to go through it, which is why we give it a blanket endorsement. We urge that the items in the ACE submission be given serious attention and be implemented by the ministry.

**The Vice-Chair:** Thank you very much for your presentation. We have four minutes left. We can divide them equally among the three parties. We'll start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. You always do a great job, Bill, on behalf of the people you represent in the province.

You spoke about the air conditioning, and that was one of the issues that was brought to my attention over the course of the summer, the fact that it was an unusually hot summer and that's likely to continue. But currently, there's no obligation to ensure that the residents are comfortable in their rooms as far as temperature. I hope the government will take into consideration the need to consider adding some sort of amendment that will reflect that concern, because it was a big, big issue over the course of the summer.

**Mr. Gleberzon:** We know the predictions are that this summer is going to be worse.

**Mrs. Witmer:** Is it going to be worse?

**Mr. Gleberzon:** That's what I've heard.

**Mrs. Witmer:** Well, that's maybe good news. But anyway, we thank you for all the work you've done.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you for being here today. It's nice to see you again. I want to just focus on your endorsements, the first one with respect to Royal Canadian Legion, Ontario command, and their call for an ombudsman. The government has tried to put forward the notion that this Office of the Long-Term Care Homes Resident and Family Adviser is going to do the trick here. The Legion certainly doesn't seem to think so. I wonder if you have any views that you want to share as to whether



or not an adviser who essentially is not independent is going to be what is required so that families have comfort that their complaints are being investigated properly and that they are getting some redress for the concerns that they're raising.

**Mr. Gleberzon:** Our experience with ombudsmen—ombudspersons, whatever—with some exceptions, is that generally they become the defenders of the institution they work for and often try to deflect the complaints that are being raised. That's why the issue you've raised, the fact that what's being suggested in the bill would not be an independent office, is one that has to be reviewed very seriously. We think that an independent ombudsman is the way to go. We think the Legion is absolutely correct in that regard, because the office will be totally independent, beholden to no one other than those people who come forward with their complaints and concerns.

**Ms. Martel:** So if the current Ombudsman had his mandate expanded to include oversight, would that suit your purpose too?

**Mr. Gleberzon:** Sure it would, because the current Ombudsman is one of the exceptions that I talked about.

**The Vice-Chair:** The parliamentary assistant?

**Ms. Smith:** I want to address some of your concerns. With respect to the reference to personal hygiene, the bill of rights does require that the person's needs are met. If you look at section 4, I think you'll see it there. In the plan of care in sections 6(3) and 6(4) and again in section 7 we talk about nursing and personal care needs being addressed. So I think your concerns will be addressed through those sections and those requirements in the legislation.

On the air conditioning, the irony of Mrs. Witmer's position today is just too much for me to bear, given that under her regime they set the building standards for 20,000 new beds across the province and didn't include the requirement for air conditioning. So for her to say now that over the last summer she's become aware of a concern about air conditioning is just way too much for me to handle.

Obviously, we have concerns about the building standards that were set by the previous government as well as the build that they did, in some cases, in a lot of the wrong places, and we're trying to address that through the tools that we're providing in the legislation. So I do hear you on the air conditioning and I just wanted to draw to Mrs. Witmer's attention that she did have the opportunity to address that.

On your concern about personal liabilities for directors, we do hear that.

With respect to training, we do have a list of provisions on what kind of training we expect and we do have the ability in regulation to add to that list. So I will take that.

Do I have one more second? Look at him; he's looking at me badly here.

On your issue with respect to the ombudsman, just a quick question: For the most part, the generic role of ombudsmen is to investigate an issue that has already

taken place. We've had different submissions on people wanting advocacy, wanting assistance with the system and wanting investigation of issues. Do you see the role that you envision being an investigative role, an advocacy role or one of assistance to seniors who are trying to manage the system?

**Mr. Gleberzon:** All of the above. If we take the example of Mr. Marin's study on realty tax, he covered the whole waterfront in all those three areas. To me, that's the kind of model that we would be looking at.

Can I just make some other points? In regard to hygiene, we think it's necessary to have a specific item or clause on the issue of hygiene. I agree that they can be covered under those areas.

**The Vice-Chair:** Thank you very much for your presentation. We went a couple of minutes over the time.

1430

#### FAMILY COUNCIL NETWORK FOUR

**The Vice-Chair:** Now we move to Family Council Network Four. Welcome, sir. You can start any time you are ready.

**Mr. Robert Gadsby:** Good afternoon. My name is Robert Gadsby. I am chair of a local family council in Hamilton but I come to you this afternoon in my role as chair of Family Council Network Four. The handout will provide you with my remarks today.

Family Council Network Four represents the family councils, which are all volunteers, from the 87 long-term-care homes, comprising about 10,000 beds, in the Hamilton Niagara Haldimand Brant region, the region which is also referred to as local health integration network 4.

Our goal is to support local family councils as we strive to make a difference to improve the physical, emotional and social well-being of residents in the homes. Our focus is on our loved ones—family and friends—who often cannot speak for themselves.

We have received input from family councils both inside and outside of our region. This is a consolidation of key issues and concerns regarding Bill 140, which we hope will help the committee with its public hearings and reviews.

Residents of our long-term-care homes include senior citizens who have made a major contribution to what we have in Ontario today and veterans who have fought for our freedom. They deserve a homelike environment where there is respect, dignity and quality of life.

We applaud the government for its initiative in Bill 140 to: enshrine the Residents' Bill of Rights; encourage the formation of family councils in all long-term-care homes; ensure that all long-term-care homes provide high standards of care.

Our major concern is not with what Bill 140 says, but rather with what it doesn't say. The following is a summary of key issues and concerns.

On the preamble to Bill 140, this is a description of beliefs, goals and objectives that are excellent. However,

it is not clear how these good intentions are reflected in the bill itself. For example, the terms "quality of life," "homelike environment" and "resident-centred care" appear only once in the bill, and that is in the preamble. By contrast, the term "quality of life" appears over 20 times in the earlier report by Monique Smith, *Commitment to Care: A Plan for Long-Term Care in Ontario*. We are concerned that the bill does not address some of the key commitments necessary to help to improve the quality of life for our loved ones in long-term-care homes.

Regarding hands-on personal care time, we had expected to find a commitment to more time for hands-on personal care in the bill. Ontario remains well below many other jurisdictions in the amount of personal care provided to residents. Bill 140 does not stipulate minimum staffing levels or minimum hours of care.

We have a great deal of respect for staff members, but there is a chronic shortage of staff in our long-term-care homes. The increased number of residents with dementia or serious disabilities means that front-line staff are stretched to the limit simply to meet the day-to-day needs of all residents. Despite the best efforts of staff, and even with volunteers and families pitching in, residents are often only receiving the barest essentials of care. For those who have dementia or need one-on-one attention, some families have had to resort to hiring a health care aide from an outside agency to help feed and care for their loved ones. This situation does not reflect a suitable quality of life and it results in an institutional rather than a homelike environment.

We look forward to the government providing the funding and staffing commitments to permit at least 3.5 hours of hands-on personal care per resident per day.

Regarding training and standards, we endorse the requirements for adequate staff training and for high standards of care in all long-term-care homes. We expect the government to provide adequate funding and staffing commitments to ensure that the training needs can be met without any loss of hands-on personal care.

Regarding the use of temporary, casual or agency staff, we support the goal of ensuring that our loved ones, particularly those who are suffering from dementia, experience continuity and consistency in their care. However, we are concerned that by limiting temporary, casual or agency staff, there may be times when this results in short-handed shifts. In an ideal world, we would like to see the same staff caring for our family members day after day. However in the real world, we know that having an adequate number of staff is far more important than striving for consistency.

Regarding meeting long-term-care needs in the local community, we are concerned that seniors need to have access to long-term-care homes which are close to their local communities so that their families can visit easily, often via public transit. We are also concerned with the uncertainty that has been created regarding the future of some older long-term-care homes. In many communities, these long-term-care homes are the only facilities

currently available. Family members are worried that these homes may not be available or that their loved ones may be moved to other homes, where it will be much more difficult for them to visit.

There needs to be a defined program to assess and establish future needs for long-term care within local communities, but there is no reference to this process in the bill. Once our loved ones become residents, there needs to be sufficient staff and funding for outings, recreational and social activities, which will help maintain their links to the local community.

Regarding equality and access to services, we expect the government to help ensure that accommodations with modern standards of comfort and dignity are available for all long-term-care residents, now and in the future. For example, semi-private rooms with wheelchair-accessible washrooms should be the minimum standard. In Manitoba, there are currently only 63 four-bed rooms in the entire province. Ontario has thousands. Funding for capital renewal is needed to help bring accommodations for all residents up to modern standards now, not in 10 years' time.

Regarding funding, we are concerned that the bill does not indicate how the government will fulfill its election promise to "invest in better nursing home care, providing an additional \$6,000 in care for every resident." Regarding food, we are concerned that the funding provided to long-term-care homes for raw food is only \$5.46 per resident per day. We had expected to find a commitment to improve the funding in the bill or in the government's budget.

Regarding family councils, we are pleased that Bill 140 provides a mandate for family councils. We recognize that while it is difficult to make a volunteer organization mandatory, all long-term-care homes should be strongly encouraged to have a family council.

We welcome the opportunity for "a person who lives in the community where the long-term-care home is located" to become a member of the family council. We would note that the individual must also be interested in making a positive contribution to the activities of the family council.

Regarding quality of life, quality of life includes ensuring that there is adequate staffing and funding available for recreational and social activities, physiotherapy and restorative care, counselling and special needs. The support of a social worker is also an important element to help not only the resident, but also the family. It is not appropriate for a long-term-care home to be placed in a position where it must depend on the efforts of family members and the community to pick up the slack in order to meet the needs of residents.

We look for the government to make the funding and staffing commitments that are necessary to truly achieve the objectives referenced in the preamble to the bill: "preserving and promoting quality accommodation that provides a safe, comfortable, homelike environment and supports a high quality of life for all residents of long-term-care homes."



I'm sure that all member of the committee share the goal of ensuring that our loved ones in long-term-care homes enjoy a high quality of life. I thank you for your attention.

1440

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can start with Ms. Martel. You have one minute.

**Ms. Martel:** I apologize that I was out of the room for part of your presentation. I'd want to start with the last thing that you had to say, which is that "We look for the government to make the funding and staffing commitments necessary to achieve the objectives...." I think that is key. The government promised \$6,000 per resident in enhanced funding; they're at about \$2,000. If they actually met their commitment, you probably would be able to have the staff necessary to implement 3.5 hours of hands-on care per day, as an average. So we will see what will happen there.

Generally speaking, in your work and in your colleagues' work, what are the top concerns that you see as family members with respect to your loved ones in the homes that you're representing?

**Mr. Gadsby:** We're looking at their day-to-day attention, and so the front-line workers are really important to facilitating the needs of our family members and friends; in addition, recreation, to make sure that people in the homes feel that they are still part of the community and it's a homelike environment. I'm fortunate with the home I'm associated with, but not all family councils are in a similar position, where residents have the opportunity for recreational outings and social activities.

**The Vice-Chair:** The parliamentary assistant, one minute.

**Ms. Smith:** I want to thank you, Mr. Gadsby. It's nice to see you. I know I was supposed to see you in October. I'm coming next month, so I look forward to it. I appreciate the great work that you're doing in your family council network in the Hamilton area.

I just want to address a couple of things that you raised. When you talked about the quality of life, homelike environment, resident-centred, I think if you look through again, in our section 6 on "Plan of care" we talk a lot about a resident-focused plan of care and ensuring that the resident and their family or substitute decision-maker understand the plan of care, making sure that everyone who's involved in the care of that resident is involved in setting up that plan. So we really do try and make the care for the resident resident-focused. As well, with the presence of the residents' council and the family council, we try to include the broader family of that resident in the life of the home.

I appreciate your comments on the staffing. On the limiting of agency staff, obviously we're going to ensure that they're only used when necessary, but we will always make sure that we have the amount of staff that's needed.

You talked about the needs for activities. I know that you're familiar with the activity coordinators and the fact

that we funded their program last year. They're developing a best practices manual across the province which we hope will be implemented in all of our homes. In the legislation, we do mandate that there be activity programs for our residents in our homes, as well as a volunteer program, which is not intended to pick up the slack but is intended to increase community in the home.

**The Vice-Chair:** Thank you.

**Ms. Smith:** Sorry, we could go on.

**The Vice-Chair:** I know you can go on.

Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. I certainly appreciate it. You've given us some good insight into what family councils feel are important for residents. I guess, despite what we hear from the government, the reality is that we could be providing more hands-on care and more time with the residents if the government would live up to the promise it made to provide an additional \$6,000 per resident. They have not lived up to that promise; they've only delivered about \$2,000.

As a result, I'm just seeing now, for the first time, the fact that people are having to hire these health care aides. I'd not heard about it before, but recently I've been in to a couple of homes. That concerns me because, again, it's two-tier. If you can afford to hire someone, then obviously your loved one has that additional staff support, but we should be ensuring that the government live up to the obligation, invest the money per resident for additional care, and we wouldn't be in that state.

**The Vice-Chair:** Thank you very much for your presentation.

#### YEE HONG CENTRE FOR GERIATRIC CARE

**The Vice-Chair:** The next presentation will be by the Yee Hong Centre for Geriatric Care. Welcome, sir. You can start whenever you're ready.

**Dr. Joseph Wong:** Thank you very much for this opportunity to address you. I am Dr. Joseph Wong. I'm the founder and chairman of the Yee Hong foundation and also the Yee Hong Centre. Florence is the CEO. We are very, very glad to be here to, first of all, let you know that we are very glad about many of the initiatives which are being proposed in Bill 140. There are a number of focuses that have not been given due consideration, and for the Yee Hong Centre, this is our most important task.

The Yee Hong Centre was first built in 1994. For seven years before that, we were actively lobbying the government and soliciting help from the government to establish a home that is sensitive to the different cultural and language needs of the residents of the GTA and also of Ontario.

As many of you know, Ontario is home to many immigrants. In the recent past, 30 to 40 years, most immigrants have come from Third World countries—over 70% as a matter of fact—and most of them came to Ontario, in particular to the GTA. More than 51% of

Toronto's population was born outside of Canada. In particular, many are from Asia—China, India and south-east Asia—and have now claimed Toronto as their home. In this regard, I'm very glad that in the preamble of Bill 140 you did address that it is important for long-term care homes to pay particular attention to the cultural and language needs of various residents.

But let me give you my example, the reason why Yee Hong was set up in the very first place. Let us not just pay lip service to the cultural and language needs of these long-term-care residents. Let me tell you my own experience with working in nursing homes in downtown Toronto when I was a resident at Toronto Western Hospital.

A number of years ago, back in 1978, I encountered a lot of Chinese seniors in different nursing homes in downtown Toronto. Of course, I was told various horror stories. Many of these were not due to inattention on the part of the nursing home but were actually due to barriers because of language and culture. They were not getting appropriate services from those homes because of unfamiliarity and also because people were not able to understand them fully. Their physical needs and emotional needs were not met.

Many of the Chinese residents who I met through these homes asked me, "Dr. Wong, can you help me kill myself?" That is the kind of life that they led. They really could not tolerate life without anyone understanding them. They were not able to express very simple life needs, such as going to the washroom, a headache or whatever, and did not get proper attention from the staff because of the language and cultural barriers.

So I started dreaming of Yee Hong and also planning for Yee Hong beginning in 1987. The first home was established in 1994. Subsequently, in the last 10 to 12 years, we further expanded the original centre and also built three more new centres, not only for Canadians of Chinese decent but we also dedicated many beds to different communities. For example, we have a floor of 50 beds dedicated to Canadians of south Asian decent in our Markham home; in Mississauga Centre, we have a wing of 25 beds dedicated to serving Canadians of Filipino origin; and in our new Scarborough home, we have one wing of 25 beds also dedicated to serving Canadians of Japanese decent. In that way, we really are able to deliver culturally and language-appropriate services.

Now, this is very important as it's different from a hospital, in which anyone would say at the end of their stay, whether it be 10 days or 30 days, "I will be able to get the hell out of here." But in a nursing home, you just cannot. You have to spend the rest of your life there. The barriers in culture and language really make them feel so much more isolated. They are very frustrated and they don't see the light at the end of the tunnel. That is why they prefer death rather than living.

At the Yee Hong Centre, our experience has been extremely positive. In the last several years that we have been serving not only Chinese but also different seniors

from different communities, life has been very positive and life has been worth living again. With the initiatives in Bill 140, I believe that every home will improve. But on the other hand, I don't think that you have put appropriate time and effort into making sure that our homes offer language- and culture-appropriate services to these residents. So this is number one, the most important thing that we want you to address today.

#### 1450

Number two, for those of us who organize a centre for seniors, not only an isolated nursing home but actually a geriatric care centre for seniors offering them comprehensive services in a continuum-of-care fashion, taking care of the healthy to the very frail and many in between—and in housing, which is next to the nursing home. We have a lot of people who have to depend on supportive housing services in order to be independent, in order to continue to live in their own dwelling, in their own units. They find a lot of freedom and a lot of independence and dignity living that way. There's no reason why this could not continue. We are actually saving the government a lot of money because we are delaying these people from entering nursing homes on a premature basis. Even if they are rightful candidates for the nursing homes, because of our effort, because of our supportive services, they are able to continue to live there without applying for nursing home accommodation.

So this is really a win-win situation: Win because they are able to lead a better life in our housing units and win for the government, win for the public because they are not using so much public money in this regard. On the other hand, when they really need it, at the end of the day, when they reach the road that services, no matter how good at home, would not be able to deliver such professional—and also, some services are only able to be delivered in nursing homes. So in this regard, they really need to go into a nursing home, but we penalize them by asking them to go to a different nursing home than the one we established next door. This was the very original idea why we needed to establish a centre: so that we could give them a choice of going into a housing unit. And then when they need it, they could go into Yee Hong just next door, under the same roof, as a matter of fact. This is the reason why we ask you to consider giving centres such as Yee Hong, established for the mere purpose that these people can continue to live in Yee Hong even though they do not need nursing home accommodation at a particular time—at the end of the day, they might need it and they might be given a priority or some sort of choice to go into Yee Hong at the time when they need it. So these are the two extremely important points that I want to address today. I would like to ask Florence Wong, my CEO at the centre, to give you specific recommendations.

**Ms. Florence Wong:** Thank you, Dr. Wong. In our written deputation we have listed nine areas in which we really applaud the government in this bill. Because of time, I'm not going to go over them. As well, we do share in two general concerns expressed by other depu-



tants to this public hearing. Again, because of time I'm not going to go over that, but instead, we will focus on aspects of the bill pertaining to ensuring continued availability of culturally and linguistically appropriate services in the long-term-care sector.

Dr. Wong has gone into a lot of detail about giving priority to seniors in the continuum. I'm not going to repeat that, but I would like to continue with our four other suggestions. The first one is respecting cultural, ethnic and linguistic diversities in the bill itself. The bill in its preamble talks about respecting diversity in communities, but in setting out the fundamental principles, it seems to have lost what is available in the long-term nursing home act right now referring to the cultural and spiritual needs of each resident being adequately met. So we recommend that this wording from the nursing home act be put back into Bill 140.

Our second recommendation pertains to the "how" in delivering long-term-care services. Subsection 6(4) of the bill listed all the services that are to be provided, including medical, nursing, personal care, dietary etc. However, it missed the essential point of how these services have to be provided in order to meet the residents' ethnocultural and linguistic needs.

We therefore recommend that the bill make explicit that operators of long-term-care should demonstrate cultural, ethnic and linguistic sensitivities in planning and delivering long-term care. We believe that this is very important in ensuring the quality of life of these residents.

Our fourth recommendation pertains to, when the minister considers whether to grant a licence, to renew a licence or withdraw licences in certain areas, that he consider the capacity locally and in other places as well as funding. However, we strongly feel that long-term-care homes that meet specific cultural and linguistic needs of residents typically serve seniors from many geographical areas that cross political and LHIN boundaries, Yee Hong being one of them. It is therefore very essential, in determining whether to grant or withdraw licences for culturally specific long-term-care services, to consider population needs beyond the specific local area, and to make explicit that the cultural and linguistic needs in the area and other areas be considered in granting and withdrawing licences.

Our fifth and last recommendation pertains to who is entitled to be a member of the family council. In fact, we are presenting this on behalf of the family council of the Yee Hong McNicoll long-term-care home. The family council expressed grave concern about the provision that a person who lives in the community where the long-term-care home is located can be a member of a family council. Our family council feels strongly that an outsider—someone who just lives in the community—may not have the same knowledge and vested interest as a family member or a person of importance to the residents or a former resident. They feel that if expert advice is required, they would rather develop an expert panel for a specific purpose. They really want us to request the gov-

ernment to remove the provision for a person who is not a family member or person of importance to a resident or former resident to be a member of the family council.

Once again, we want to applaud the government for its commitment to improving resident care through Bill 140. We sincerely believe that the recommendations that we make would make the bill even stronger in ensuring the continued availability of culturally appropriate care in the long-term-care sector. Thank you.

**The Vice-Chair:** Thank you very much. We have one minute left. I guess we won't open the floor for questions. We're going to move on to the next presentation, which will be—

**Mrs. Witmer:** Mr. Chair, I'd just like to thank Dr. Wong and Ms. Wong for being here.

I think you've done a tremendous job in providing culturally and language-sensitive homes for the people in this community, and I applaud you for your efforts, and also in educating us. I know that I appreciated meetings that I had with you. We need to look to the future, because it's going to be equally important; in fact, perhaps more so.

**Ms. Smith:** Just because it's a rare occasion that Mrs. Witmer and I are agreeing these days, I do want to join with her—and I'm sure Ms. Martel does as well—in thanking you both. I've had the privilege of visiting two Yee Hong centres. You're doing a great job. Thank you so much for coming today.

**The Vice-Chair:** Ms. Martel, since everybody spoke, go ahead.

**Ms. Martel:** Thank you for being here today. I've seen you before on other pieces of legislation as well. You take a very acute interest in health care issues, and we appreciate that.

**The Vice-Chair:** Thank you very much.

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#### CANADIAN PENSIONERS CONCERNED, ONTARIO DIVISION

**The Vice-Chair:** The next presentation will be by Canadian Pensioners Concerned, Ontario division.

**Ms. Christine Mounstevan:** Thank you. My name is Christine Mounstevan. I am president of Canadian Pensioners Concerned, Ontario division. To my right is Gerda Kaegi, who is a past president and now standing board member.

We are grateful to the members of the standing committee for giving us time to make a presentation to you on this proposed legislation.

Canadian Pensioners Concerned Inc. was founded in 1969. It is a national and provincial voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

We are grateful and particularly pleased that the government has taken the time to research and review the evidence that has been accumulating that there is a need for new legislation dealing with this complex area of

health and social policy. We commend you for the effort you have made to consult widely and to listen to what we have heard. We are very supportive of most of what is included in Bill 140 but believe that there is room for some improvements.

We have five overarching themes that inform our brief: (1) the primacy of non-profit—which includes public sector homes—provision of care in the Ontario health care system; (2) the need to give explicit and precise recognition to the ethnocultural needs of Ontarians in this legislation; (3) the critical importance of protection for the residents of long-term-care homes; (4) the need for training for all those providing services in the system of long-term-care homes; and (5) the need for long-term sustainable funding that will ensure that the excellent objectives of the legislation can and will be carried out.

Our detailed brief follows the order of topics found in the bill; however, for the purposes of our presentation we will focus on the five themes noted above.

(1) The primacy of non-profit provision of care: Section 95 refers to the balance between for-profit and non-profit provision, and we believe that this is inadequate. As in the discussions over the act creating the LHINs, many people argued for the primacy of the non-profit sector—and won. We are also concerned about the one-sided handling of the transfer of beds, section 103.

(2) The need to give explicit and precise recognition to the ethnocultural needs of Ontarians in this legislation: The absence of explicit requirements to meet the ethnocultural needs of Ontarians is striking. We have provided recommendations in a number of areas where this must be addressed, such as the residents' bill of rights and training programs.

(3) The critical importance of protection for the residents of long-term-care homes: Too many cases over too many years have brought the public's attention to the vulnerability of people living in long-term-care homes. We strongly support the actions taken by the government in this legislation to ensure protection for residents, but we believe that more can be done. Some examples are the use of more definitions in the interpretation section; the number of registered nurses; minimizing of restraints; inspections and enforcement; and training requirements.

(4) The need for training for all those providing services in the system of long-term-care homes: We commend the government for recognizing the importance of training for all those working for and with residents in long-term-care homes. However, we argue that more can be done, and there is a need for clarification of the requirements found in the bill. Some examples of what we have looked at are the standards and programs of training and the requirement for training in the ethnocultural needs of residents, the elimination of abuse and neglect.

(5) The need for long-term sustainable funding that will ensure that the excellent objectives of the legislation can and will be carried out: We realize that levels of funding are not part of this legislation, nor can they be. However, we are deeply concerned that unless the

funding is stable and adequate to carry out the excellent intentions of this bill, the system will fail and the people of Ontario will have lost an important opportunity to protect the lives of their vulnerable citizens. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have a lot of time—about eight minutes left. We're going to divide it equally between the parties. We'll start with the parliamentary assistants. Ms. Smith.

**Ms. Smith:** I appreciate what you had to say. I'm sorry, I was following along with you and then flipped forward to see some of the particulars that you were looking for around definitions. When you talked about the importance of protection of residents and that there was more work to be done, aside from the definitions of "abuse" and "restraints," I was interested in what more you thought could be done around minimizing the use of the restraints and our sections on inspection and enforcement. Are there specific areas that you feel could be strengthened?

**Ms. Gerda Kaegi:** Yes. Let me deal with compliance and enforcement. We're really pleased with the fact that you're going to have unannounced inspections. When I was on the advisory committee of what was then the Metro Homes for the Aged, we knew weeks in advance before the inspectors were coming in, so they were really a farce. At the time we were pleased, but still—we're delighted, but we believe there should be no exceptions at all in this area, so we have problems with that.

The minimizing of restraints: Unless there is clear definition of the meaning of "restraints" and the range of restraints that can be used, we are concerned because there are now examples of people who are "restrained" from leaving a home who are perfectly capable of leaving a home, but it's somehow not defined as being restrained from leaving a home. We're concerned that that kind of legal definition be spelled out. We refer to the expertise that the Advocacy Centre for the Elderly would have around something like that.

**Ms. Smith:** One of the suggestions that had been made around the exception for annual inspections was a way of recognizing the good homes that, for three or four years or whatever number we come up with, have had no unmet standards. They would then be given a gold star and exempted from an annual inspection the following year—with the proviso, of course, that if there is any report or any issue that arises, obviously an inspector would be in to review that immediately, just as they would with any other incident in any other home. I take it from what you're saying that you don't agree with that type of recognition.

**Ms. Kaegi:** No, we don't.

**The Vice-Chair:** Thank you very much. Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. You've emphasized in number (5) that despite the fact that this bill is well intentioned—and it certainly is; there are certainly many good points made within the bill—unless there is stable funding provided to carry out some of the additional tasks and some of the additional requirements, it's not going to lead to improved quality



of life for the people in the system. I hope that the government, who did make a commitment almost three and a half years ago to provide the additional \$6,000 per resident for care, will follow through on that, because if that money was needed three and a half years ago, with the additional requirements in this bill and the additional paperwork, it is going to become even more necessary.

I do appreciate that you've also indicated the need to recognize the ethnocultural needs of Ontarians in the legislation. I think if we take a look at who's living in the province of Ontario today, that's going to become much more significant in the future than it even is today. I certainly do appreciate the input you've provided.

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**The Vice-Chair:** Thank you very much. Ms. Martel.

**Ms. Martel:** Thank you for your participation here today. I want to focus on section 103 in the bill. You said on page 2 of your brief that you are concerned about the one-sided handling of the transfer of beds. That section of course refers to the ability of the director to transfer a bed under a licence. I'm assuming you want some broader consultation or a committee or something that has more input.

**Ms. Kaegi:** Yes, we would like more input. We also believe that that section reflects primarily on the non-profit side. If you are looking at non-profit beds—they are community-based, they come from the community, public tax dollars and so on—we believe that if necessary, if beds have to be transferred, those particular beds should go back into the ministry to then come back to another non-profit facility. We don't believe that there should be a transfer from the non-profit sector of beds, as necessitated by perhaps a closing of beds in the facility, to the for-profit sector.

**Ms. Martel:** In terms of a closure, okay; just a bit about that: The director is not required to provide reasons for deciding whether or not to issue a new licence.

**Ms. Kaegi:** We believe that they should provide reasons.

**Ms. Martel:** And that should be public.

**Ms. Kaegi:** Everything should be public and there should be reasonable grounds, I mean an appeal route, for the decision of the director. But, ultimately, every bit of documentation must be in the public domain.

**The Vice-Chair:** Thank you very much for your presentations.

#### BAYCREST GERIATRIC HEALTH CARE SYSTEM

**The Vice-Chair:** Now we'll move to the Baycrest Geriatric Health Care System. Welcome to the standing committee on social policy. Before you start, please state your name.

**Mr. Stephen Herbert:** Dans quelle langue? Is English preferable?

**The Vice-Chair:** Yes, as long as we don't have interpreters.

*Interjection.*

**The Vice-Chair:** We do have interpreters.

**Mr. Herbert:** Good afternoon. My name is Stephen Herbert. I am president and chief executive officer of the Baycrest Geriatric Health Care System.

On behalf of Baycrest and its clients, families, staff and board of directors, thank you for this opportunity to speak to you about Bill 140. I'd like to introduce three people who have accompanied me and help us stay connected to the needs of long-term-care residents and families whom Baycrest serves. On my right is Irma Singer, chair of the Baycrest residents' council. On my left is Gail Kaufman, chair of the Baycrest family advisory council. On my far right is Paula Schipper, counsel. Today, Irma and Gail have asked me to outline the comments of the council on their behalf. They're here to make sure I get it right and also to respond to any of your questions. Needless to say, Baycrest heartily supports the insightful comments of its residents and family advisory councils. They know what they're doing.

By way of background, the Baycrest Geriatric Health Care System is an academic health centre affiliated with the University of Toronto. It is a charity that provides a range of health services for seniors, including independent living, assisted living, supportive housing, a rehab and complex continuing care hospital, community services, research and, last but not least, the Apotex Centre, Jewish Home for the Aged. The Apotex Centre is a 472-bed, long-term care facility currently comprising 372 approved home-for-the-aged beds and 100 licensed nursing home beds.

Baycrest applauds the government's decision to combine homes for the aged and nursing home regulation under one statute. It makes sense for all long-term-care homes to be licensed under one regulatory scheme.

Bill 140 goes further than a licensing scheme. It establishes rules to control the use of restraints on residents, to prevent abuse, to set an appeal mechanism for admission to secure units, to have annual satisfaction surveys and family councils, and to require that employees, volunteers and contractors undergo criminal screening and prescriptive training. All of these are laudable measures. They are designed to protect residents of long-term-care homes and also ensure their voices are heard. We support that. The care of the elderly is why we are all here today and what Baycrest is about.

But it cannot go unsaid that the measures proposed by Bill 140 come with a price tag—all regulation does—and we are afraid. We're afraid that no additional funding to implement and sustain these changes may compromise the ability of long-term-care homes to do their essential tasks: to provide the care and supervision that long-term-care residents need. We're concerned for Baycrest and, frankly, we have no idea how smaller homes will cope. We will be submitting several proposed amendments in writing. I'd like to highlight some issues for you now and explain why some parts, not all, of Bill 140 are problematic.

Research shows that seniors' health is impacted positively when they reside in a culturally sensitive environ-

ment. For seniors of the Apotex Centre, Jewish Home for the Aged, this means providing kosher food, programming of a Jewish nature, including spiritual support, and providing special support to our residents and their families who survived the horrors of the Holocaust. Approximately 50% of the Apotex residents are survivors. Baycrest is one of the only organizations the Jewish community can turn to for a culturally sensitive environment. The cost of this is approximately \$500,000 in operating costs annually for the Apotex. Other non-profit organizations such as Yee Hong and Villa Colombo also provide culturally sensitive care and service which ultimately benefits the welfare of residents. I believe it contributes positively to their quality of life. The legislation should promote the provision of culturally sensitive care and service and help support it through appropriate funding.

We support the recognition of family councils under Bill 140. Baycrest's family advisory council has existed for 15 years, and before that, for many years, floor councils. We believe that this has made a valuable contribution and is essential to our ability to provide client family-centred care.

Both the family and residents' councils do not believe that a substitute decision-maker should have the right to sit on a residents' council, as allowed under subsection 54(2). Their experience is that while at times families and residents share the same concerns, most often their issues are different. Irma has told us that our residents' council is worried that families sitting on the residents' council may influence the direction of the council. You might think that our family advisory council would support a substitute decision-maker sitting on the resident's council as well as on the family advisory council. They do not. In their words, "Families can dominate the discussions and the resident's voice may not be given fair weighting against the family perspective if the membership exists" as written.

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Under subsections 56(1) and 59(2), a long-term-care home shall appoint residents' and family advisory council assistants who are acceptable to the councils to assist them. In our experience, each of these have been Baycrest employees, as the duties can be time-consuming and require people familiar with the home's operations. It is inappropriate for an employee to take instruction from the residents' or family council. The assistant's role is more about bridge-building; the assistants act as liaisons between the licensee and the councils and report back to the councils. Baycrest supports its family council's submission, which provides as follows:

"We assume the assistant will be an employee of the long-term-care facility and thus cannot function as a completely neutral individual. We are also concerned that no new funding will be added to support this role within the ... facility; a council assistant should not be hired at the expense of programming or some other aspect of residents' care. The Baycrest model has worked quite well if the person is able to act as a liaison between the

two parties. Bringing information and issues back and forth from the two groups has been a significant role of our liaisons to the residents' and family councils at Baycrest. We believe that this proposed reporting may set up an adversarial role between the councils and the long-term-care administrative staff."

Under subsection 23(5), the government's director for long-term care may receive information about the operation of a long-term-care home and decide not to send an inspector. Instead, the director may refer the matter to, among others, the residents' council or family council.

Baycrest's family advisory council has advised us that they do not want to be positioned as an adversary to Baycrest under the legislation. Furthermore, residents' and family councils are not equipped to do investigations, as would be the case with an inspector. This is an ombudsperson or government role. In the words of the family advisory council, "As highly functioning as Baycrest's councils may be, we are not equipped to mediate or serve an inspection role. Smaller long-term-care homes would be even more challenged in this role."

I'd like to mention one other proposal that our family council feels strongly about. Currently, there is an expectation that a long-term-care bed must be given up after a 21-day medical leave. This can be extended for a further 30 days, but only if the resident pays a bed-holding fee on top of the regular charges. This is in regulation. Many residents on reduced co-payment do not have the means to pay the bed-holding fee. The council feels that this regulation does not recognize the importance for a person to return to their previous environment following a hospitalization. This could be accommodated by giving these individuals priority on the waiting list, which they lose now, or by offering more flexibility if the person's medical leave is longer than 21 days and the person is ready to return shortly thereafter.

Regarding the mandate for policies on zero tolerance of abuse under Bill 140, Baycrest, of course, believes abuse or neglect of residents is intolerable. "Zero tolerance" is a buzzword that refers to an admirable principle. The reality, however, is that labour proceedings often require an employer to maintain an employee in his or her position notwithstanding that some abusive or neglectful behaviour on the employee's part has occurred. If not amended, this provision means that Baycrest and other homes may eventually be put in breach of their own policy and the Long-Term Care Homes Act, despite their every effort. We strongly advise that either the rule of zero tolerance be modified or, if abuse is truly not to be tolerated, that arbitrators at labour proceedings be prohibited from reinstating an employee where there has been a finding of abuse.

Subsection 43(1) governs rights advice and the appeal process for residents being admitted or transferred to a secure unit in the home. The bill defines a secure unit as "a part of a long-term care home that residents are prevented from leaving."

**The Vice-Chair:** You have three minutes left.



**Mr. Herbert:** What I miss will be sent in to you.

**The Vice-Chair:** No problem.

**Mr. Herbert:** In Baycrest's Apotex Centre, over 75% of residents are in units that are locked unless a button or keypad is pressed. Although such secure units by definition prevent residents from leaving, they are neither sufficiently secure nor adequate for the care of very difficult-to-manage residents. Care for such residents requires a greater number of employees and extra equipment, like helmets and door posies, than the funding by government currently enables. However, homes are funded for secure units no differently than regular units. If having secure units as defined under the bill means that long-term-care facilities such as Baycrest will be targeted to receive more difficult-to-manage clients, then we are very concerned about risks to our residents and staff.

While it might be appropriate for such locks on unit entrances to be considered a restraint for purposes of section 30 and to trigger rights advice and an appeal, subject to reasonable limits, a truly secure unit must have much more than a locking device on a unit entrance. It needs a higher staff-to-resident ratio, adequate training and funding for specialized equipment.

We are concerned about the potential number of Consent and Capacity Board hearings this provision could trigger. Such proceedings, while designed to be expedient, are often time-consuming and take staff away from the care of other residents. They could also slow the flow of admissions from hospitals and the community to long-term-care homes. The waiting times for people occupying alternative levels of care in acute care hospitals will increase. With regard to transfers within the long-term-care home, already stretched staff resources will be necessary to give rights advice, unless an outside agency will be given this task in regulation, and to appear on behalf of the long-term-care home as a party at hearings.

There are several staffing requirements under the bill.

How am I doing?

**The Vice-Chair:** Half a minute.

**Mr. Herbert:** I'll just finish this one point, then.

The first enables the government to limit by regulation the number of temporary, casual or agency staff a home may use. For continuity of care, we agree that permanent staff is optimal for residents. However, temporary or casual staff will always be necessary to fill in for permanent part- and full-time staff who are entitled to have vacation, leaves and the like.

Maybe I should stop there and just see if there are any questions. We'll forward the rest to you.

**The Vice-Chair:** There's no more time for questions. As you mentioned, please send us your presentation and we'll send it to all the committee members.

**Mr. Herbert:** Yes, we will.

**The Vice-Chair:** Thank you for your presentation.

## ONTARIO DENTAL HYGIENISTS' ASSOCIATION

**The Vice-Chair:** The next presentation will be by the Ontario Dental Hygienists' Association. Welcome. You can start whenever you are ready.

**Ms. Margaret Carter:** Thank you. My name is Margaret Carter. We are here today representing the Ontario Dental Hygienists' Association, known as the ODHA. I am the executive director of the association. With me here is Margaret Detlor, a dental hygienist practising primarily in long-term care in the Kincardine area and currently serving as vice-president of the association.

ODHA is the voluntary professional association representing Ontario's registered dental hygienists, one of the health professions regulated under the RHPA, or the Regulated Health Professions Act. Dental hygienists are highly skilled in helping clients to attain and maintain optimal oral health.

On behalf of our entire membership, we are pleased to be here today to provide our comments regarding Bill 140.

As a whole, the ODHA supports in principle the intent behind Bill 140. Consolidation and improving the regulatory framework for Ontario's long-term-care homes is a laudable goal. There are sections, however, that we have serious concerns about and urge you to consider amending.

As members of the oral health care team, dental hygienists are responsible for client-centred professional treatment that helps to prevent periodontal or gum disease and dental caries or cavities. They provide a process of care that involves assessing the oral condition; planning treatment according to individual, community or population needs; implementing the treatment plan; and evaluating the success of the treatment and planning for the future.

Dental hygienists also focus on disease prevention. Clinical research has established a strong link between oral health and overall health. For example, did you know that some heart surgeries are delayed or cancelled because the patient needs to have his or her teeth scaled or cleaned before surgery to reduce the risk of post-operative infection, or that diabetics who keep their mouths clean and healthy require less insulin? Since diabetes can lead to complications with vision, kidney function, neuropathy, wound healing, cardiac function, cerebrovascular and peripheral vascular problems, good oral health helps reduce the risk of further complications.

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Did you know that bacterial respiratory infections may be caused by the aspiration of bacteria from the mouth and throat into the lungs? When these bacteria reach the lower respiratory tract, they may cause infection or worsen pre-existing lung conditions.

Dental hygienists do more than just remove plaque and floss teeth. They contribute in a large part to their

clients' overall health through the prevention of oral disease and the promotion of oral health care.

Today's seniors are keeping their natural teeth far longer than seniors of the past. After committing a significant number of resources to their teeth and oral health, it is unfortunate that many residents in long-term-care homes in Ontario find their oral condition declining rapidly once they have been admitted to a home. Part of this is likely due to the private funding aspect of oral health care and is compounded by a significant misunderstanding of the relationship between oral health and overall health. In many situations this misunderstanding could be alleviated by an explanation provided by a member of the oral health care team.

ODHA believes that one of the most fundamental personal care tasks is oral care. It is very clear from the reports we have received from our members that residents in long-term-care homes seldom receive basic oral health care assistance, let alone the twice-daily assistance mandated by the province.

Too many residents in long-term-care homes are suffering from rampant decay and periodontal disease. Excessive plaque left on the teeth day after day causes decay and periodontal disease. In addition, over time, as disease in the mouth increases, teeth are lost, nutrition declines and the individual's overall health and ability to fight disease declines and the burden on the health care system increases.

We have heard of situations where a resident had not had her dentures removed since admission because no one was familiar enough with the oral cavity to even recognize that her teeth were false and removable, and unfortunately the outcome was catastrophic. We have also heard of oral cancers that are undetected; of residents who have not been able to consume solid or semi-solid food for months who are back to eating solids after having a diseased tooth or teeth removed; that residents considered by staff to be uncooperative and violent became co-operative and friendly after having a diseased tooth or teeth removed and the pain relieved; residents whose partial dentures are loose due to decay and disease in the teeth required to support the dentures such that there are numerous abrasions and lesions in the mouth, often causing significant pain. We have also heard that staff in long-term-care homes report that a resident's general health improved once an oral health care routine and services had been established in the home.

If long-term-care homes are used as a measure of other areas of assisted living, then there is significant work to be done in educating all health care workers about the importance of oral health and the mechanics of assisting in daily oral health care.

Staff in long-term-care homes should be required to have standardized basic oral health education to enable them to assist clients with their oral health care and twice-daily routine, to understand that there are connections between oral health and overall health, to recognize when to seek assistance from dental hygienists and other oral health care professionals, and to understand the

role of, and request assistance from, dental hygienists in establishing oral health regimens.

With specific reference to Bill 140, oral health and oral hygiene should be explicitly included in the references to health care services and plans, and programs of care. Of particular note is the reference to a plan of care in subsection 6(4).

An admission oral health assessment should be performed by either a dental hygienist or a dentist and the results of this assessment should then be incorporated into the resident's initial and subsequent plans of care.

The program of personal support services referenced in subsection 7(2) should specifically include oral hygiene. Prescribed duties of the director of nursing in sections 69 and 70 should include oral health care coordination.

With respect to the provisions in section 22 of Bill 140, ODHA is concerned that there is no definition of "neglect" and yet there is a requirement to report it. In addition, the use of the words "improper treatment" is very subjective without a definition. "Abuse" is carefully defined by the legislation and yet "neglect" and "improper treatment," which have the same statutory mandatory reporting provisions, are not.

If improper treatment is captured by the concepts of malpractice, incompetence and incapacity on behalf of a practitioner, then the Regulated Health Professions Act has a well-articulated and well-established process for dealing with such matters. It needs to be clear that for regulated health professionals, the RHPA takes precedence over Bill 140; otherwise there may be some dispute or jurisdictional challenges, with the effect that the practitioner is not called to account.

The complaints process within Bill 140 provides for an alternative route for dealing with complaints such that the behaviour may never be brought to the attention of the regulatory college. In addition, in some situations, allegations may be very specific to the profession, making it all the more important that these issues be addressed by the regulatory colleges that have the expertise, experience and processes already in place. It is our view that any allegation of misconduct, including abuse, malpractice, or incapacity by a regulated health professional, must be referred to the regulatory college of the professional in question.

ODHA supports mandatory reporting of abuse, incompetence and incapacity, as such individuals should be removed from practice, allowing for due process, of course, as soon as possible and in the public interest. However, professional misconduct should not be included in the mandatory reporting requirements for the following reasons.

The definitions of professional misconduct or improper treatment may vary considerably among the regulatory colleges, and this requirement would essentially mean that a practitioner would have to be familiar with all of the professional misconduct provisions, including, for example, record-keeping and advertising. Unlike most incompetence and incapacity concerns, some



professional misconduct can be quite trivial in nature. Requiring interprofessional reporting of all professional misconduct will likely result in widespread non-compliance. The requirement will also likely be a great deterrent to interprofessional collaboration and practice. There may be an overwhelming number of frivolous, vexatious and retaliatory reports in the guise of "I have to report you." And the broadness of the reporting requirement demeans and trivializes the mandatory reporting requirements generally.

There may well be a place for generic professional misconduct provisions that are applicable for all health care practitioners that could be prescribed for the purposes of mandatory reporting, and such provisions should include situations where there is an obvious potential for harm or injury.

We do appreciate the opportunity to speak to you today. We are grateful that the government is willing to listen and work together with stakeholders and service providers seeking input and advice. We would be happy to take any questions that you have should there be time.

**The Vice-Chair:** Thank you very much. I guess we have three minutes left. We divide them equally among the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. Let me go to your recommendation that oral health be included in the plan of care that is listed in subsection 6(4), which would mean that the home would also be responsible for the costs associated with that, either a dental hygienist or a dentist coming into the home to do that for each client, correct?

**Ms. Carter:** I would suggest that would be a factor that would have to be included in it, and I think that's probably part of why oral health care is not recognized as part of overall health care.

**Ms. Martel:** All right. There's a cost there, but it's one that should be looked at and then a decision made. I think it's important enough that that should actually be considered and should be included as part of overall care.

I'm not sure that I clearly understood your concerns, however, around the manner of reporting. We would need, I gather, an amendment that would clearly say that the RHPA would take precedence over any other aspect of this bill with respect to reporting of abuse and neglect. You'd like to see that?

**Ms. Carter:** I think anything that triggered an allegation of incapacity, incompetence or malpractice should be referred to the regulatory college of the professional involved.

**The Vice-Chair:** Thank you very much. Parliamentary assistant.

**Ms. Smith:** Just to follow up on that question, with respect to improper care, your suggestion would be that it should be reported to the college and not reported within the home.

**Ms. Carter:** I still think there are provisions that it can be reported within the home, but our concern is that it doesn't go further than that. We do want to make sure that the public is protected by the processes that are

incorporated in the RHPA which deal with the professionals themselves.

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**Ms. Smith:** Right. But you, as a professional in the college, have a requirement to report inappropriate treatment or malpractice, for lack of another term. That's independent of the requirements that are in this legislation. Is there anything in this legislation that suggests to you that this legislation would supersede your college requirement to report?

**Ms. Carter:** I think wherever there are two pieces of legislation that have the same sort of outcome, i.e., there's a complaint being processed, there's always the potential for challenges of jurisdiction. I think that the one thing we don't want is to see someone not be held to account for their lack of care or a problem.

**Ms. Smith:** I'll sneak one more in. In the plan of care question that you've raised, you talk about the need for an initial assessment and that the dental or oral hygiene be included in the daily plan of care for the resident. So the role for the hygienist or the dentist would be to do that initial assessment. Do you foresee another role or a requirement that we have the hygienist coming into the home in any other—I'm trying to figure out how much money this could cost, so I'm just trying to find out, as part of that plan of care, do you foresee a hygienist or the dentist requiring further visits, further assessments, or is that on a case-by-case basis?

**Ms. Margaret Detlor:** It is on a case-by-case basis. However, as a dental hygienist working in long-term care, if I were able to be a part of that initial assessment and be a part of the care for that entire person, as opposed to just that one little portion, their health would be improved by adding dental hygiene into it.

**The Vice-Chair:** Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Margaret, for your presentation. I think you've raised a good point: Thus far, the whole issue of providing oral health care to the people in the long-term residence has been overlooked, and I think it's becoming much more important that it be included as we move to the future. So I appreciate the recommendations that you make here.

I think the whole issue of the fact that there's going to be some duplication with the Bill 140 reporting and also the Regulated Health Professions Act obligations is something that the government needs to take a look at, because I would agree with you: It does take precedence over Bill 140 and there are issues that obviously more appropriately should be dealt with by the professional body. So I would even ask, Mr. Chair, for the people to do a little bit of research and just share with us, what is the intent of Bill 140 when it comes to complaints that would normally be dealt with by the professional college? There seems to be some conflict here. If we could maybe get some understanding—

**The Vice-Chair:** Are you asking the research department to do this stuff? Can you give specific questions?

**Mrs. Witmer:** Yes. I'd like to know what is going to happen in accordance with Bill 140 when a health

professional has an allegation, if there's an allegation. What's the possible conflict with the RHPA? Because it is supposed to take precedence, and I think we need to be very clear on who looks after what. I think it is an issue. We had the nurses here today and they just assumed, I think, that the college would take precedence. I asked them about the whole issue of abuse and they said, "Once action was taken, obviously the individual would probably lose their licence and not be allowed to return to the long-term-care home." So I think we need to take a look at that.

**The Vice-Chair:** Okay, the researchers are going to do their best to find out—

**Mrs. Witmer:** Okay. We need some clarification as to what's meant by Bill 140 and what the normal role of the RHPA would be, because normally the precedents would be there in that legislation.

**The Vice-Chair:** Mrs. Witmer, I guess the researcher is going to do their best in conjunction with the ministry staff, the legal department, so we'll see what's going to happen. When they get that information, it will be shared between all the parties.

**Mrs. Witmer:** All the parties, yes. Thank you.

**The Vice-Chair:** Thank you for your presentation.

## ONTARIO FEDERATION OF LABOUR

**The Vice-Chair:** We now move to our next presentation. It will be by the Ontario Federation of Labour. Welcome. You can start whenever you are ready. Please, before you start, state your name. You've been here many different times, so you know the procedure.

**Ms. Terry Downey:** Thank you. Good afternoon. My name is Terry Downey. I'm the executive vice-president at the Ontario Federation of Labour. With me today as well from our federation is the director of health care, Duncan MacDonald. I'll be making our presentation on behalf of the federation.

We welcome this opportunity of appearing before the standing committee on social policy to discuss the Long-Term Care Homes Act, Bill 140.

The sad state of long-term care in our province has been noted by many. For example, the long-term-care facilities section of our October 2005 report, *Understaffed and Under Pressure: A Reality Check* by Ontario Health Care Workers, which I believe you're being handed now—I hope you get an opportunity to read it at length later on—found many examples of concern with respect to health care workers. I would like to read a couple of examples to you.

In terms of the understaffing issue, "Why isn't there more staff? We're exhausted. We're all working doubles and this employer is so cheap they won't hire any more people."

Another health care worker indicated, "I'm getting bladder infections because there is no time to pee. We have big trouble getting to the bathroom. I'm running all day. If you are on a water pill, if you have to hold it,

you're much more prone to bladder infections. It's not just me."

As a last example, I want to show you a flavour of what folks are saying: "Residents in these retirement homes, well, it's not a good situation. People off the street, call them Bobby or Sally, are now giving you shots and meds. Legally they are required to work under the guidance of a registered staff, but dream on. There is no RN on nights and so they are forced to do this. I mean, anyone and their dog can be pressed into duties in Ontario retirement homes, no matter how untrained they are."

So for our members, Bill 140 is a flawed piece of legislation reflecting the betrayal of Ontarians by this government, in our view. It's a betrayal of the wishes and needs of our seniors. It's a betrayal of Ontarians who provide quality care in facilities across this province. It's a betrayal of Ontario families who have members in these facilities. And it's a betrayal of the wider community of Ontarians who believe that quality care for those in need is both desirable and attainable.

The government knows the state of long-term care in our province. Bill 140 reflects the attitudes and actions of a government that does not listen to Ontarians.

I want to talk to you about our vision for long-term care. The Ontario Federation of Labour constitutes the largest provincial labour federation in Canada. The 700,000 members of the OFL are drawn from more than 1,500 locals of 40 different unions. Our members work in all economic sectors and live in communities across Ontario, from Kenora to Cornwall and from Moosonee to Windsor.

Since our founding convention in March 1957, the OFL has consistently advocated for our vision of a universally accessible public health care system for all Ontarians. Our vision for health care draws on the experiences of, firstly, dedicated health care workers who provide needed services and who are profoundly troubled by the misdirection of public policy and the failures of the institutions which employ them; and also workers and their families who in the past used or continue to use the services of Ontario's health care system.

Our vision for health care is outlined in two recent documents, one of which we have provided for you, which is the *Understaffed and Under Pressure* report. The other is our major policy paper entitled *Rebuilding Health Care*, which is available on our website. It was developed with the valuable assistance of our affiliate unions in health care—I'm sure you've heard from many of them over the last two days—and discussed and endorsed by delegates to our last convention in November 2005.

In May and June 2005 the federation, working in conjunction with affiliated health care unions, sponsored meetings in 15 communities to examine the consequences of understaffing. The report is a record of first-ever meetings of health care workers from all sectors and unions. They came to a mutual conclusion: that all sectors and workplaces have been hard hit by under-



staffing and that the problems associated with understaffing and its consequences are systemic and serious.

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On the issue of long-term care, we have worked closely with our affiliated unions in health care. These unions have thousands of members who are dedicated workers who provide quality services in this sector across Ontario. We have also worked closely with our community allies through organizations such as the Ontario Health Coalition, which I know has presented to you already as well.

Our policy paper on rebuilding health care called for specific actions which the McGuinty government could begin to implement immediately in the long-term-care sector. We are asking for:

- a required minimum standard of 3.5 hours per day of nursing and personal care for residents;

- staffing levels that reflect not only the number of staff but also the appropriate classification and qualification of staff to ensure residents receive care that is appropriate to their needs;

- soliciting of ongoing input into long-term-care policies by workers through their unions, residents and their families;

- increased capacity of workers to have a say in what is happening in their facilities by instituting regular, unannounced inspections and mandating inspectors to speak with residents, family and workers about conditions; whistle-blower protection to be implemented for workers who complain about conditions and for the protection of residents;

- mandatory reporting and monitoring of staff levels instead of the Liberals' voluntary compliance. This will ensure that there is proper use of government monies.

There are a number of broad areas of concern that we have with Bill 140. They include (1) the lack of staffing standards; (2) identification of the needs and solutions; (3) undermining of the non-profit sector; and (4) geographic differences in standards.

Let me first address the lack of staffing standards. The most fundamental flaw of Bill 140 is that it does not address the chronic and critical understaffing issues in long-term care. We believe that the legislated province-wide staffing standard is necessary if we, as a society, are serious about addressing the needs of this sector. This is an action we expect our government to take on behalf of all Ontarians whether or not they are now, or will become, residents or workers in long-term-care facilities.

There was a staffing standard previously of 2.25 hours of minimum nursing and personal care per patient per day until it was eliminated by the previous Conservative government under Mike Harris in 1996. Ontarians became aware of the implications of this action. In 2001, a PricewaterhouseCoopers study reported that Ontario had the lowest amount of total care hours per nursing home resident per day in a sample comparing Canadian provinces, a number of American states and a European country—the Netherlands.

The Ontario Liberal Party joined with others at that time who sought the reintroduction of staffing standards. On November 7, 2002, the Liberal Party introduced a resolution in the Legislature stating "that, in the opinion of this House, the Ernie Eves government should immediately establish minimum standards of care for nursing homes and homes for the aged, including the reintroduction of minimum hours of nursing care and the requirement for a minimum of at least one bath a week." Many of the Liberals who spoke in favour of this resolution in 2002 are now playing a variety of roles in the Liberal government of Dalton McGuinty.

Dalton McGuinty, in his April 4, 2003, response to a question from the Ontario Federation of Labour, stated, "We have a comprehensive plan to improve the quality of life for residents of long-term-care facilities. Our plan includes restoring standards and providing the necessary funding to increase the level of nursing care that long-term-care residents receive. Inspectors will be required to audit the staff-to-resident ratios, the number of nursing hours per patient, the mix of staffing and number of staff who have taken a course in the care of seniors."

In December 2003, in response to a series of investigative articles into the long-term-care sector in the *Toronto Star*, as you know, the Minister of Health and Long-Term Care, George Smitherman, promised a "revolution," and that fixing this problem would be his "top priority." But by October 5, 2004, in a meeting of the standing committee on estimates, the same minister had changed his tune and said that he would not be reinstating the 2.25 hours staffing standard. Even an April 2005 coroner's jury report into the deaths of two residents in a Toronto nursing home in 2001, which made 85 recommendations, including the need for staffing standards, has not moved this government.

So through Bill 140, the government did not see fit to bring in staffing standards and to implement what had been so recently their party policy. There is even some talk that while staffing standards were not addressed in Bill 140, a section of this bill, section 36, dealing with regulations, could be used to bring in staffing standards.

A staffing standard of 3.5 hours per day of nursing and personal care per resident has broad support among Ontarians. It is supported by our members who work every day in this sector. They know what human resources must be in place in order to provide for the needs of Ontarians in the long-term-care sector. It is obvious to us that a dedicated, stable workforce with expertise and experience is vital in providing for the needs of Ontarians in the long-term-care sector. This can be attained if the government implements a staffing standard of 3.5 hours, at a minimum, per day of nursing and personal care per resident.

I want to speak now about the identification of needs and solutions. Many Ontarians have been involved in identifying both the problems and the solutions for our long-term-care sector. The government could have used this public interest in order to develop a vision of and a legislative framework for an effective long-term-care

sector in our province. This would have provided the opportunity for Ontarians to see clearly what the government is suggesting, as well as giving them the opportunity through public hearings, much more expanded ones than this current schedule, to suggest improvements.

Perhaps this government lacks a complete vision of what we see as the role for the long-term-care sector. Section 1 of Bill 140 states, "The fundamental principle to be applied in the interpretation of this act ... is that a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort."

A more inclusive and fundamental principle is found, however, in the Nursing Homes Act, one of the three pieces of legislation which will be repealed and replaced by Bill 140. It states that "a nursing home is primarily the home of its residents and as such it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others."

**The Vice-Chair:** Excuse me, you have one minute left.

**Ms. Downey:** We think this is a clearer picture, and this should be put into the bill as opposed to what's currently there.

We also talk about issues around training and the undermining of the non-profit sector. We really believe that a public and non-profit provision of long-term care is

better suited to identify and serve the needs of Ontarians than a for-profit system geared to serve the needs of corporations that seek to improve their financial bottom line.

In conclusion, we think that the sad state of long-term care in our province is of concern to Ontarians, and that the government has an obligation to show leadership in dealing with the issues that we have laid out, verbally now and also within our presentation. Our members believe that you cannot have quality care without people. To this end, a staffing standard is a necessary first step. The second step is for the provincial government to commit itself to a non-profit model for long-term care. Taken together, this will ensure that we have access in the communities—

**The Vice-Chair:** Thank you. The time has expired.

**Ms. Downey:**—and the kind of service that will serve the needs of the long-term-care sector in our communities. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. There is no time left for questions. Thank you to everyone.

Before we adjourn, we have an announcement. To my understanding, the three parties have talked about the space on the plane that will be available for the staff on a chargeback basis. Is this agreed? Agreed.

Now we are adjourned until the 22nd of this month. The meeting will be in Kingston, Ontario, at 9 o'clock. We'll see you then. Thank you very much.

*The committee adjourned at 1600.*









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Second Session, 38<sup>th</sup> Parliament

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**Journal  
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**Standing committee on  
social policy**

Long-Term Care  
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**Comité permanent de  
la politique sociale**

Loi de 2007 sur les foyers de  
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Chair: Ernie Parsons  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Monday 22 January 2007

Lundi 22 janvier 2007

*The committee met at 0906 in the Ambassador Conference Resort, Kingston.*

## LONG-TERM CARE HOMES ACT, 2007

LOI DE 2007 SUR LES FOYERS DE SOINS  
DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

**The Vice-Chair (Mr. Khalil Ramal):** Good morning, ladies and gentlemen. Welcome to Kingston, Ontario. Welcome to the standing committee on social policy. We're in the third day of hearings on Bill 140, An Act respecting long-term care homes.

We have many presentations. They will take us all the way to 4 o'clock this afternoon.

## FAIRMOUNT HOME

**The Vice-Chair:** We're going to start this morning with Fairmount Home. If they are here, they can come forward and start when they are ready.

I know that probably you know the procedure. You have 15 minutes. You can speak for all of the 15 minutes or you can divide it between presentation and questions from both sides of the table. You can start whenever you're ready.

**Mrs. Julie Shillington:** Thank you. Good morning, ladies and gentlemen. I'm Julie Shillington, administrator from Fairmount Home. With me today is Mary Lake, our director of resident care.

Fairmount is a 128-bed, accredited, non-profit municipal home dedicated to providing the best quality of life for those who live and work at Fairmount. Fairmount opened originally in 1968 as a 96-bed home. An expansion and renovation project was completed in 2004, allowing 32 additional residents the opportunity to live with us. Our Fairmount community fosters a creative and responsive environment in which all members—staff, families, volunteers, students, community partners and the residents themselves—respect and promote the strengths and abilities of each other, especially for those for whom Fairmount is home. All members of our community are advocates for all of those who live and work at Fairmount.

I feel it is important for you to note that the taxpayers in the county of Frontenac and the city of Kingston make a substantial financial contribution to our home over and above the contributions of government and residents. Only with this contribution can we meet current legislative requirements and standards and provide the quality of care which we feel our residents deserve.

Fairmount endorses the spirit of Bill 140, which appears to be intended to promote an accountable and resident-centred long-term-care system for Ontario. We agree with the fundamental principle that a home is a place where residents may live with dignity and in security, safety and comfort, and we understand the need for monitoring and continuous quality improvement. Through partnerships with our residents, family members, government and the Fairmount community, we've been successful in providing quality care for many years.

We're very concerned, both on a fundamental and practical level, about the way the government proposes to apply the provisions as set out in Bill 140. We welcome this opportunity to provide observations and specific concerns from Fairmount's perspective.

As a not-for-profit care provider, we're extremely disappointed that Bill 140 does not include clear statements of support for not-for-profit care delivery. The current government has been vocal in its support for not-for-profit health care and we feel it's important that this continue through this piece of legislation.

Not-for-profit long-term-care homes are respected and recognized not only for their dedication and commitment to quality of care and service delivery but also for the active and integral role they play as employers, supporters and contributors to their local communities. Being not-for-profit means that 100% of the resources are invested in the interests of the residents, and any surplus income is used to improve facilities or expand service.

We urge the government to amend the legislation to include a strong and explicit statement of support for the not-for-profit sector, a statement that commits the province to preserving and promoting not-for-profit long-term-care delivery.

Under Bill 140, a director or officer is guilty of an offence if he or she does not take "reasonable care" to ensure the corporation complies with all requirements under the act, and the penalties are harsher than those that apply to individuals sitting on hospital boards. A fine of

\$25,000 or a 12-month jail term will prove to be a significant impediment to recruiting and retaining qualified board members.

We ask the government to consider the implications of this legislation on a home's ability to retain and recruit qualified and committed board members and amend it accordingly.

**Mrs. Mary Lake:** Fairmount has active resident and family councils, and we have worked hard together to ensure the collective needs of our residents are met. We are concerned that the proposed legislation may put the home and our residents in conflict by allowing individual families and residents the right to enforce individual rights even where such enforcement may infringe on the collective rights of all residents.

While we support provisions that minimize the use of restraints, we do not support the application of the same provisions to secure units. We have a secure dementia unit at Fairmount which provides for resident safety and special care where we can offer programs that meet the residents' unique needs and staff with the expertise to do so. The proposed amendment under Bill 140 to the Health Care Consent Act, section 42, refers to criteria for admissions to secure units by substitute decision-makers, one of which is that the admission allows the incapable person greater freedom or enjoyment. This is important. Admissions are not always due to the risk of serious bodily harm; in many cases, they are due to invasion of privacy of other residents, who then get angry, resulting in increased frustration and confusion for the resident with dementia. In a secure unit, the resident has the freedom to wander without upsetting other residents, which prevents catastrophic reactions for the residents themselves.

Bill 140 also requires placement coordinators to give the person being admitted to a secure unit written notice and to notify a rights adviser when he or she is being placed in a secure unit. The rights adviser must then meet with the person and explain the person's right to apply to the Consent and Capacity Board. Residents who are incompetent cannot understand the implications or risk. In many cases, the prospective resident does not want to come to the home, and the substitute decision-maker is suffering from extreme guilt. This process will exaggerate the situation, adding more stress to the caregivers, who are already overburdened and burned out.

We urge the government to consider these implications and amend the legislation accordingly.

We are also concerned that Bill 140 proposes a significant increase in regulation, which will mean less money available for actual resident care. We are concerned that without additional funding, we will spend more time on compliance and administration, which means less time at the bedsides of the residents. As an example, the requirements with respect to training and education are proposed to apply not only to staff but also to volunteers and contracted services. This introduces another level of compliance, which will be very onerous, given the broad range of people and third parties.

Bill 140 allows for written agreements to be voidable within 10 days. Fairmount has a waiting list of over 170 individuals, over 70% of whom are waiting for basic accommodation. We are very concerned that this clause will allow prospective residents the ability to manipulate the wait-lists and jump the queue by coming into the home agreeing to pay for a preferred accommodation bed and then voiding the written agreement within 10 days of signing. This would lead to a loss of preferred revenue and an increase in bad debts and would impact those in the community who are waiting for and can only afford basic accommodation.

We urge the government to consider the financial impact of this legislation on the homes and the burden on those with limited financial resources in the community, and to increase operating funding to assist homes in meeting the new requirements.

**Mrs. Shillington:** In closing, we are committed to providing quality care to our residents. We support measures to enhance standards and ensure accountability, but establishing new requirements and standards without providing the means to achieve them is only setting us all up for failure. The government's commitment to increase operating funding to \$6,000 per resident has not been achieved, and this should be addressed before further pressure is exerted on our already thinly spread resources.

We ask the standing committee to consider our concerns and recommendations presented today. Only by revisions being made to both the proposed legislation and the funding scheme will we be able to maintain the level of care to which our residents have been accustomed.

**The Vice-Chair:** Thank you very much for your presentation. We have five minutes left; we can divide it equally between the three parties. We'll start with Ms. Witmer.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** Thank you very much for your presentation and thank you very much for the excellent care that I know that you personally deliver to your residents.

Certainly I share your concern about the directors and the liability. I have friends who sit on boards for municipal homes for the aged, and this is certainly a concern that they're already taking a look at. They're wondering if they're really going to want to continue to serve on those boards, with the liability that comes with it.

I guess one of the biggest problems that we're facing is the fact that the government hasn't lived up to its promise to provide an additional \$6,000 per resident. I'm wondering, if the government were to give you the additional \$4,000—it's about \$4,000 that each resident is short—do you think this would help meet the requirements of this legislation? Has anybody done a costing as to the implications of this bill?

**Mrs. Shillington:** We haven't done a costing yet; we haven't seen the regulations yet. But anything that the government could provide would go a long way.

**The Vice-Chair:** Ms. Martel.

**Ms. Shelley Martel (Nickel Belt):** Thank you for your presentation this morning. You said that taxpayers



in the county of Frontenac and the city of Kingston already make a substantial contribution. Can you give us an idea of what that is on an annual basis?

**Mrs. Shillington:** It's close to \$2.5 million.

**Ms. Martel:** Two and a half million dollars, over and above what you get from the government of Ontario. With that, you are able to provide additional staff that you wouldn't be able to otherwise. So that's what you're already getting from another source because of a short-fall.

It's clear that there are additional requirements in the bill, and it's also clear that the government is only providing about a third of what it promised. So what has to go hand in hand with this legislation is the rest of the money that was actually promised.

I want to ask you what your process is for admitting someone into a secure unit.

**Mrs. Lake:** Our process is that we look at the actual needs of each resident. Basically, it's the people who wander—not necessarily just those who would wander away from the building or out in the cold, like today, but also those happy wanderers who invade everyone else's space. They get yelled at, they get frustrated, and then they have catastrophic reactions. They just need that area where everyone else will let them be. We just go with the flow. There's no schedule; there are no routines. They can just be themselves and go where they want when they want.

**The Vice-Chair:** Parliamentary assistant.

**Ms. Monique M. Smith (Nipissing):** I'd like to join with Ms. Witmer in congratulating you because I have heard of the great care that you provide as well. We thank you for being here today.

I've heard a number of other presentations on some of your concerns around penalties in the not-for-profit sector, but I just wanted to home in for a moment on you—you support the provisions that minimize the use of restraints, but you don't support the application in the secure units. I'm just interested in hearing you elaborate on what concerns you have about the minimal-use-of-restraints policy with respect to secure units.

**Mrs. Lake:** Number one, there has to be permission from the substitute decision-maker. Then the incompetent person has to be told about the decision and why it's being made.

**Ms. Smith:** So your concern is more about the admissions to the secure unit than the actual minimal use of restraints in the secure unit?

**Mrs. Lake:** Definitely.

**Ms. Smith:** I wasn't clear on that from your presentation. That's why I was wondering.

**The Vice-Chair:** Thank you very much for your presentation.

0920

## OMNI HEALTH CARE

**The Vice-Chair:** Now we'll move to the next presentation, by OMNI Health Care.

Welcome. You have 15 minutes. You can speak for the whole 15 minutes or you can divide it between the presentation and questions. You can start whenever you're ready.

**Mr. Fraser Wilson:** Good morning. I'm Fraser Wilson, chief executive officer of OMNI Health Care. I've been in long-term care for 20 years and served in many elected capacities at the Ontario Long Term Care Association, including president in 2002-03.

OMNI owns and operates 16 long-term-care homes in central and eastern Ontario. Most of our homes are in rural Ontario and have fewer than 80 beds. Our smallest home is 43 beds.

I thank you for the opportunity to present today on Bill 140. I am here to express my disappointment and disillusionment with the proposed new act. I had hoped that Bill 140 would move us forward to embrace the next 20 to 25 years, provide equality for all residents by introducing a capital renewal program for B and C homes, be responsive to current needs, and plan for the future.

I would ask that this standing committee incorporate the amendments proposed by the OLTCA and allow long-term care and those who work and live in it to embrace their potential.

When the Minister of Health and Long-Term Care introduced Bill 140 to operators, he stated that the proposed act will be the "cornerstone on which we build a long-term-care system that will be a model" for the rest of Canada. Nothing could be further from the truth. Ontario is the only province taking no action to replace three- and four-bed wards, and our staffing levels are amongst the lowest in Canada. Unless amended, Bill 140 will perpetuate Ontario's position in last place when it comes to the comfort, dignity and care of its residents.

I am disillusioned. All residents in Ontario pay the same amount for accommodation regardless of the home's structure and classification. In homes built to new standards, residents have the benefits of a maximum of two people to a room, smaller dining rooms and abundance of recreational and social space. In B and C homes, residents live in three- and four-bed wards, large dining rooms with 60 residents and limited social and recreational space.

Is this government sending the message that those living in B and C homes are not worthy of the same comfort, privacy and dignity as those in new homes? I had hoped that Bill 140 would recognize this inequality and outline a capital renewal and retrofit plan. Instead, Bill 140 did nothing to address the modernization of older homes or the equality of those residents living in them. Rather, the government introduced limited licences that will see C homes expire in 10 years and B homes in 12 years, with no plan for the future.

Residents, families, staff, communities and operators are especially concerned about the licensing uncertainty. Specifically, residents, families and staff are concerned whether their homes and jobs will be there in the future. They are worried that they will have to travel to new

communities to live and work. Smaller communities are concerned that they may lose employment opportunities and long-term-care services. Operators will struggle to finance their homes when there is no certainty regarding their licence renewal.

Current occupancy rates in Ontario are over 98%. Demographically, Ontario's population over 75 will increase 49% by 2016. At a time when there is an unprecedented demand for long-term-care, the licences of 263 homes accommodating 27,500 residents will expire. Is it good public policy to risk decreasing this much capacity at a time when all of it will be needed, and much more, to meet the long-term-care needs of people in communities across Ontario?

As recently as the fall of 2006, the government released an RFP for new homes in Kingston and Quinte West. Those RFPs included the provision for capital funding. Clearly this government acknowledges the need for capital assistance to construct new homes to the new design standards. It stands to reason that the same capital assistance is also needed for older homes to build to the new standards.

The previous government successfully rebuilt 16,000 D beds to new standards with a capital renewal program. In fact, members of all parties unanimously endorsed Elizabeth Witmer's private member's motion to rebuild and provide a capital renewal program for B and C homes.

The tone and authority limiting licences is even more disturbing. It states that the minister is not required to notify homes whether their licence will be renewed and the minister is not obligated to give any reason for not renewing a licence. In this age of transparency and accountability, it's astounding that such unilateral authority and secrecy would be written into proposed legislation. I ask that this draconian language be changed.

I will now focus my presentation on the care and services component of the bill. I am disappointed. I had hoped for a compliance system that focuses on outcomes and encourages initiatives. What Bill 140 proposes is more paper, process and regimentation. It is incredible to know that the rest of society and business recognize the need to embrace and empower people, lift their spirits, tap their talent and focus on what they do well, yet Bill 140 is authoritarian, disempowering, fault-finding and laced with micromanagement. Minister Smitherman and Parliamentary Assistant Monique Smith both acknowledge publicly that the majority of homes provide great care. Why is it, then, that there is a need to quash spirits, increase paperwork, over-regulate, zap flexibility and continue to stretch limited resources?

For example, as opposed to allowing homes to develop their own mission statement, there is now a prescribed process and a long list of people who have to be involved. Every home has developed and evolved its mission statements for years. Continue to trust our judgment. Take this requirement out of the legislation.

Our sector has been developing policies and documentation for decades. What message is the proposed

legislation sending by now requiring a lawyer to certify these same documents? Are we now incompetent? Delete this provision. It is offensive, time-consuming and an unnecessary expense to the system.

Compliance inspectors, who were formerly called compliance advisers, are now required to document any non-compliance for anything that does not comply with the act. This could include documentation not being completed through the shift when the practice in the home is to do so at the end of the shift. This is the fault-finding regimen that focuses on process, not outcomes. Every time there is a non-compliance filed with a home, time has to be taken to develop a plan, write the plan and communicate it with the ministry. Is this an effective use of time? Change the wording from "shall" to "may," and train inspectors to be consistent in determining whether the non-compliance is trivial or adversely impacts on resident care.

I had hoped the new act would be attainable and fair. Instead, operators got absolute responsibility to protect residents from abuse from anyone at all times. How can we be responsible for financial abuse by family members or abuse that occurs when a resident has the right to visit privately with loved ones? The committee is asked to amend the act so that operators are responsible only for those things that they can control and influence.

In a similar manner, while we support the enhanced provisions for whistle-blower protection, operators should not have to bear the onus of proof on allegations filed by an employee. This clause assumes that the employer is guilty until proven innocent. How is this fair or even constitutional? We ask that this be deleted from the act.

The new act is an opportunity to create a stronger partnership with the Ministry of Health and Long-Term Care. Unfortunately, Bill 140 proposes a lack of responsiveness and an abdication of responsibility on behalf of the ministry. I had hoped for a commitment to more staffing, in recognition that our staff are run off their feet. Instead, we got no such recognition; we got a change in the spirit of the act from one of commitment to that of unilateral discretion and abdication of responsibility. Subsection 88(1) now reads that the minister "may provide funding" where it previously read "shall provide funding." Instead of more staff, we got more rules and regulations. Instead of a continued commitment to fund care and services, we got an exit strategy for the Liberal government. What is meant by this exit strategy? It brings into question the Liberal government's commitment to seniors.

Bill 140 will set the stage for the next 20 to 25 years. As the minister stated, the "proposed act will be the cornerstone on which we build the long-term-care home system that will be a model for the rest of the country." With this committee's help and the adoption of OLTCA's amendments, it can be.

I would be happy to take any questions.

0930

**The Acting Chair (Mr. Jeff Leal):** Thanks so much, Fraser, for your presentation.



On this rotation, I'd like to start with Ms. Martel. Ms. Martel, we have about five minutes for questions.

**Ms. Martel:** Thank you for your participation today. You said you have responsibility for 16 long-term-care homes. I would assume most of them are B and C?

**Mr. Wilson:** Yes, there are. There are 13 Cs, one B and two As.

**Ms. Martel:** Can you tell me if you've done a respective budget for what it would cost to bring those homes into compliance with the new standards?

**Mr. Wilson:** In accordance with the capital renewal program that's currently in place, although \$10.35 in capital assistance was an appropriate amount for the past, we feel that we can reasonably rebuild or retrofit our homes to an amount that is indicative of that \$10.35 with an inflationary adjustment. It was established in 1988.

**Ms. Martel:** You talked about the new RFP out for Kingston—I think it's for 96 beds—and you stated that it includes a provision for capital funding. Do you know what those provisions are?

**Mr. Wilson:** I believe it makes provision for \$10.35 in capital assistance.

**Ms. Martel:** If I can ask, Mr. Chair, I wonder if research can get us a copy of that RFP. There's also an RFP out in Sudbury for 96 beds. I'd be interested to see what the provisions are around capital funding for that and actually if there are any others outside of Kingston and Sudbury that have been tendered.

**The Acting Chair:** Duly noted for research staff. Ms. Smith, please.

**Ms. Smith:** Thanks, Fraser. It's nice to see you. I understand you have some concerns around the licensing scheme, and you talk about uncertainty that it in the system creates and concerns around operators and their ability to finance their home.

I also understand that OMNI is actually being sold and that you haven't had a real problem in finding a purchaser, so I wonder about your concerns about certainty in the system when you've been able to find someone who obviously feels that there is a going concern in the business. Could you comment on that for me?

**Mr. Wilson:** Yes, I can. OMNI's predicament is different than that of smaller operators in rural Ontario that are independently owned and operated, where they have an act that will limit the licences. Their ability to renew their financing with a lending institution, when they know that there is no certainty at the end of that term, is going to be compromised.

I'll give you a good example. Ordinarily, mortgages are amortized over 25 years. If their mortgage was to renew two years from now and only have eight left, that amortization would be over a far shorter time period, and the principal and interest payments would go up exponentially and I would actually say would compromise the viability of the operation.

**Ms. Smith:** Right, but OMNI hasn't actually been negatively impacted.

**Mr. Wilson:** Not in our case.

**Ms. Smith:** I was interested in your view that the mission statement shouldn't include the involvement of family members and residents, which is what the legislation provides, because you say that every home has developed and evolved their mission statements for years. It's my understanding that some of the larger chains—I'm not sure yours—actually just implement the chain-wide mission statement. Bill 140 is attempting to be resident-focused. It's our perspective that every home should reflect the needs and values of its residents. That's why we're looking at involving these individuals in the development of mission statements.

I know that you're very involved in your residents' lives; I read your newsletter. In your view, the mission statement shouldn't include their involvement.

**Mr. Wilson:** It's a matter of time and process. To put it into legislation today would make the assumption that our current mission statements are not responsive, that they're not current and that they don't meet the needs or the culture within homes. This adds time, involvement of a whole lot of other people; it will take their time off the floor in order to make these things happen. It was simply an example: Is our time better served providing care on the floor or developing the mission statement with a whole façade of people?

**The Acting Chair:** Mrs. Witmer, please.

**Mrs. Witmer:** Thank you very much, Fraser, for your presentation. I certainly share your concern that, despite the fact that all members of the government did support my call for a capital renewal program for B and C beds, unfortunately we haven't seen any plan on behalf of the government to do so. When you go into a B and C home and you take a look at the difference between that and an A home, where people are in two-bed wards and have a washroom and private space, there's a big difference, and it's hard to believe that everybody pays the same price.

Your association did offer, certainly, a compromise position on the limited-term licensing, which I know is of concern. Have you had any response from the government on whether or not they're prepared to take a look at the compromise that you've suggested to give more certainty to residents?

**Mr. Wilson:** To my knowledge, we have not received any comprehensive response to the proposal that has been tabled by OLTCA.

**Mrs. Witmer:** I know Sid Ryan appeared before us last week, and he told us that certainly he was in dialogue with the government regarding some areas of concern. So I wondered if they had been talking to you and working with you to prepare amendments to alleviate some of the concern of residents, staff and owners. I hear you saying no, not to your knowledge.

**Mr. Wilson:** Which actually surprises us, because we are representative of the long-term-care sector, between OLTCA and OANHSS, which represents the not-for-profit sector. Nobody knows the sector like we do, yet we have not had the appropriate opportunity to interface with government. In fact, I would say that we've been pretty much shut out, which is disappointing.

**The Acting Chair:** Fraser, I just want to thank you. You've always been very kind when you've offered me the opportunity to visit your fine facilities in Peterborough. I've always appreciated your kind courtesy and your hospitality.

#### MAXVILLE MANOR

**The Acting Chair:** Next I would ask Mr. Munro to come forward, please, from Maxville Manor. You have 15 minutes, sir. Any time you don't take, we'll allocate for questions from members of the committee. Welcome this morning, sir.

**Mr. Craig Munro:** Good morning, honourable members of the Legislature, ladies and gentlemen. I wish to thank this committee for the opportunity to address some of our concerns over Bill 140. My name is Craig Munro. I am the executive director of Maxville Manor, a not-for-profit organization located in the village of Maxville, approximately 25 miles north of Cornwall. I've been the senior executive of this organization since 1977. I am a past president of our provincial association, now called the Ontario Association of Non-Profit Homes and Services for Seniors. I sat on that board for a period of years, which afforded me the opportunity to visit other communities and facilities across this province, other Canadian provinces and some facilities in the United States. As well in that capacity, I had the privilege of frequently meeting with many political and bureaucratic representatives of the various government ministries involved in the care of our seniors.

The organization I represent, Maxville Manor, originally opened in 1968 and has evolved from a 90-bed home for the aged to a full-service community seniors' organization. Our 122-bed long-term-care facility saw a \$9-million rebuild in 1994. We provide outreach services to over 300 clients in three townships located in two eastern counties. We own and operate a life-lease apartment development next door to the care facility. I ask for your indulgence in receiving our presentation.

On October 3, 2006, the Minister of Health and Long-Term Care introduced the Long-Term Care Homes Act, 2006. If it becomes law, the bill will repeal the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act and replace them with a single statute.

The Ministry of Health and Long-Term Care, under different governments, has spent several years trying to wrestle with the current three pieces of legislation by amalgamating many of the regulations under all three pieces of legislation. This current government now believes it can push through this new Long-Term Care Homes Act, Bill 140, and in so doing will reduce the amount of time available to care for residents.

We wish to address this presentation to the following main areas of concern.

**Philosophy:** Long-term care for our seniors in this province has its genesis in the not-for-profit sector and in fact was started by a few Roman Catholic religious

orders. Their efforts virtually forced the public and political representatives to take action in improving care and services for seniors. The system that evolved included the not-for-profit facilities, which were made up of municipal and charitable homes for the aged, and a host of privately owned nursing homes.

0940

Typically, the not-for-profit sector operated under two pieces of legislation through the Ministry of Community and Social Services. Their goals were mutual: provide our seniors with the best care possible within a set or negotiated financial scope.

While municipalities were required to provide a home for the aged, charitable organizations, such as Maxville Manor, came into the field with the same mutual understanding; that is, provide our seniors with the best care possible within your financial means. These facilities were supported through a consultation process with various program supervisors from the ministry. It was understood that the province, the municipalities and the charitable organizations shared a responsibility to look after our seniors in the best way possible.

Meanwhile, a number of privately owned nursing homes proliferated and were regulated under the Nursing Homes Act, administered by the Ministry of Health, to provide a minimum of service to their residents. This legislation brought inspection teams from the ministry to ensure that private operators were providing the bare minimums. Failure to do so could bring costly sanctions. Fair game, if they could provide the service and make a profit, but note the essential differences.

Our organization, Maxville Manor, a not-for-profit community-based charity, was originally conceived 40 years ago by a number of people in the community—a village of 850, I should add—concerned about caring for a growing seniors population in the area. Many of these community leaders formed the first board of directors, which was and still is composed of people from virtually every organization in the community, including voting members from each of the five area churches, two municipal entities, the local Lions Club, the Kenyon Agricultural Society—which is famous for the renowned Glengarry Highland Games, a volunteer organization of some 400 souls—and the Glengarry Old Time Fiddlers.

The development of Maxville Manor was a total community effort, drawing on the volunteer time of many of the area citizens and the generous donations of over 3,000 people from the surrounding area.

Some historical operational highlights that I would like to mention include:

We were the second long-term-care facility in eastern Ontario and 10th in the province to receive accreditation status.

We started the first life-lease development seen between Toronto and the east coast.

In 1978, we initiated the first involvement of the area psychiatrists in addressing dementias and other seniors' mental impairments. This work became the engine for the creation of the geriatric assessment team for the three united counties.



We were the first facility in the province to arrange for regular dental services through the local public health office.

We provided the first wheelchair-accessible transportation for seniors in the three united counties.

While it is always self-satisfying to be able to relate firsts and notable achievements, our motivation for pointing out the above is to demonstrate that, after 40 years of successful operation, we are not neophytes to the health system, and we do not operate in isolation.

Bill 140, in its present form, provides no sense of a shared responsibility, but rather the heavy hand of controls, sanctions, penalties and possibly even jail terms. This bill places a bureaucratic stranglehold on the delivery of care. Bill 140 proposes a significant increase in regulation that will require our staff to spend more time and resources on ensuring administration and compliance. An example is that the section of the bill dealing with training and orientation of staff takes up a full three pages of the bill.

There is no mention of the province providing any additional funding to cover any of the compliance requirements. Bill 140 makes extensive references and demands on operators to provide for all care requirements of their residents, yet this bill, as with all existing legislation, makes no mention of a minimum standard of care, hours of care or even funding associated with any care to be provided. As this ministry learned in the study carried out by the Pricewaterhouse group and funded by this ministry, even the state of Mississippi provides for some minimum level of care for its seniors, well beyond anything being funded in this province.

We appreciate the need for ongoing upgrading of homes to meet the changing needs of residents, yet there is no mention of any capital renewal funding tied to structural compliance and ultimately licensing of facilities.

Under the bill, not-for-profits will be allowed to sell or transfer beds only to other not-for-profits. There is no such restriction placed on for-profit facilities. This has the potential to devalue the equity interest of the not-for-profits and could seriously affect their borrowing capacity. The mere idea that this province now pays for-profit corporations taxpayers' money to build facilities is one that is totally foreign to and misunderstood by most people in this province.

While it may be good politics and gain good press to hammer away at residents' rights, we are concerned that the legislated individual rights of residents and families might infringe on the collective rights of all of our residents.

In the not-for-profit sector, elected municipal officials and volunteer community board members ensure that our residents' rights are protected, without the need to enshrine these in legislation.

The issue around placement of residents in our special care area, designated for those with moderate to severe dementias, should remain totally within the realm of the facility's own staff. What would anyone in a regional or

provincial ministry office know of the daily care needs of any of our residents?

Bill 140 imposes personal liability on directors for failing to take all reasonable care to ensure their homes meet all requirements of the act. Directors could conceivably go to jail for such a breach. We are concerned that this may present a significant barrier to recruiting and retaining our volunteer directors. We find it curious that the penalties in Bill 140 are significantly harsher than those affecting directors on hospital boards. Penalties under Bill 140 are up to \$25,000, compared to a maximum of \$1,000 for hospital directors. Is this type of penalty really meant to serve as a warning to the for-profit corporations making large profits in their attempt to provide the minimum service allowable?

In summary, in this government's hurry to rationalize the legislation around long-term care, Bill 140 removes any suggestion of a shared responsibility with the not-for-profit sector.

As it needs to protect the public under the for-profit system, the ministry sees it as efficient to lump us together and allow us to be tarred with the same brush.

This bill is unfair and heavy-handed, it sends a clear signal of distrust, micro-management and intimidation to the thousands of caring staff in all long-term care, and is a breach of a long-standing trust with our volunteer board members in the not-for-profit sector.

We cannot stress enough our despair at this government's desire to homogenize all long-term care so that even our community-based, not-for-profit organizations will be expected to provide only the minimum. Bill 140, while perhaps more palatable in its conception, has become a testament to a government that seems incapable of understanding what is involved in caring for our seniors.

Accountability costs, in both money and opportunity. Given the limited availability of nurses in this province, why would you want them at a computer instead of taking care of residents?

This bill should be discarded and a new direction mandated that recognizes that real caring for our seniors belongs in the hands of our communities and that at least a minimum of service should be defined and adequately funded.

**The Vice-Chair:** Thank you very much for your presentation. We have a few minutes left; we can divide it equally. One minute, Parliamentary Assistant.

**Ms. Smith:** Thank you for coming before the committee today to discuss your views on Bill 140. I was interested in one particular aspect where you talked about the fact that the bill requires that not-for-profits only be allowed to transfer beds to a not-for-profit. This was actually something that OANHSS had requested because they wanted to protect the share of not-for-profits in the system. We're now hearing from not-for-profits that they don't like that provision. So I just wanted to hear your views on that a little more clearly, please.

**Mr. Munro:** I'm not clear if the association specifically asked for that type of wording. I understand that

the bill was changed in anticipation that this might appear or be of some benefit to the not-for-profit sector. In fact, it's a detriment.

I'll use the example: If our organization, which is a local community charity, wanted to get out of the long-term-care business but continue providing services to seniors, as we do with life-lease units and outreach and so on, we would only be able to sell our licence, if you will, to another not-for-profit facility, as opposed to some other private corporation that might come down the road. That's going to be a detriment to our ability to—

**The Vice-Chair:** Thank you very much. Mr. Yakabuski.

**Mr. John Yakabuski (Renfrew–Nipissing–Pembroke):** Thank you very much, Mr. Munro, for joining us this morning. You've made some excellent points, and I just want to touch on a couple.

Clearly, you believe that this bill, as it's presently written, without proper funding, will lead to less care for residents, not more, as opposed to what the government believes. It looks like your concern is that you could lose board members—good-quality, volunteer board members. Would it be fair to say that the government is scapegoating long-term-care operators and declaring war on them because it's good politics to spread this message that they're out to protect residents, and using your industry as a scapegoat?

0950

**Mr. Munro:** I think the government is coming down very hard on long-term care in their haste to rationalize the three pieces of legislation. They have to protect the public in the for-profit system, and I can understand that. They are operating for profit. They are not there for any other reason. Our not-for-profit facilities exist only to care for people. That's our only motivation; it's not to make a profit.

**The Vice-Chair:** Thank you. Ms. Martel?

**Ms. Martel:** Thank you for your presentation and for a long and very noble history in the community.

You mentioned your concerns about the penalties, and I note how diverse your board of directors is. Has the board of directors itself taken a look at the provisions around penalties, and, if they have, what are their concerns or comments in that regard?

**Mr. Munro:** As with any volunteer board, they are going to turn to their professional staff and say, "What kind of reporting do we have to have in order to ensure that every piece of this act is being looked after?" You can imagine the kind of reporting requirements that's going to create for the paid staff and how long our board meetings are going to become to make sure we're presenting the kind of documentation that's going to be necessary for them to review to make sure that we're meeting every care need of every resident.

**Ms. Martel:** Have you any sense of the time that it will take to do that?

**Mr. Munro:** No. I couldn't even venture a guess.

**The Vice-Chair:** Thank you very much for your presentation, sir.

## ROSEBRIDGE MANOR

**The Vice-Chair:** The next presentation will be by Rosebridge Manor. I also want to remind the audience that we have a lot of coffee and tea, if you want to help yourself, and juice too. It's open for anyone who wants to have a coffee or tea.

Welcome. Please, before you start, can you state your name for Hansard.

**Mrs. Nelly Hobbs:** Good morning. My name is Nelly Hobbs. I'm the administrator of Rosebridge Manor in Easton's Corners. I've been a care provider and advocate for residents, families and staff in long-term care for over 20 years, and I proudly say that we are for-profit, but we certainly have endeavoured to and do provide more than the minimum standard.

I would like to introduce David Kent, who is the chairperson of our family council. He has agreed to represent residents and families by addressing their concerns with Bill 140 to this committee.

**Mr. David Kent:** Good morning. Just a brief mention about myself. I'm a retired federal government worker who spent 30 years doing policy and legislation for the federal government on a national basis, so I have some idea of what it takes to put a bill through. I have no political or business reasons for being here. My reason is strictly for my father and other people who are residents of the homes.

My father has been a resident at Rosebridge Manor for three and a half years now. He is a World War II—

**The Vice-Chair:** You're David Kent, right?

**Mr. Kent:** Yes, I'm David Kent. Sorry; I didn't say my name, did I?

**The Vice-Chair:** Just to make sure. No problem.

**Mr. Kent:** He is a veteran of World War II and contributed to Canada and the Canadian economy all his life, not only through his service in the community but also through charitable endeavours and through all his work life. I have agreed to speak before the committee because I am concerned that parts of Bill 140 will have a negative impact on care and the home environment, to ask the committee to amend the bill to support our home in providing the care that our loved ones need and deserve, and to support the staff in ensuring that they are able to sustain and improve the home-like environment. I know, through frequent interaction with the staff at our home, that they are dedicated to providing the best care and support for our loved ones. Without your support to make changes to this bill, however, their job will become even more difficult than it is today.

Rosebridge Manor is a relatively small rural home located in Easton's Corners. It has provided services to residents of Leeds, Grenville and Lanark since 1977. Statistics show that demands for this service will not only continue, but will increase in the future.

The home has established strong linkages and partnerships with the community over the years to improve and enhance care and services to the residents. This includes services for the residents provided by a strong volunteer



program and a long-term relationship with the BPH geropsychiatry team, as well as relationships with contractors and other service providers to ensure the safety and comfort of our loved ones.

In addition, the home is a major employer in this rural community, employing approximately 80 direct staff, as well as providing employment for other services such as foot care, hairdressing and physiotherapy.

Although Rosebridge Manor strives to provide an excellent level of care and has become the extended family for many residents, there are serious inequities in the funding and structural amenities of homes such as ours across Ontario which make this effort much more difficult. We pay the same as families in newer homes, yet we still have four-bed wards and large dining rooms with 50 or 60 residents. Should our loved ones not expect the same level of comfort, privacy and dignity as those in newer homes? Our home represents 78 out of 35,000 residents in Ontario who get noticeably less money for their efforts. This standard is not just and is certainly not equitable, or acceptable either.

Not only have we been overlooked with funding and capital improvement initiatives, but now, because of the wording of Bill 140, we are uncertain about the future of our home and the services it provides to the community. The ambiguity of the language around licence renewal and criteria for renewal of the licence is disconcerting. This ambiguity and the uncertainty create extra stress on residents, families and staff. How can a home attract and retain competent leaders and staff when the very existence of the home is uncertain? How can financing for mortgages and improvements be arranged when owners will not be able to say with any degree of certainty how long their home will be able to operate? How can homes maintain their occupancy when they are not able to assure the community that they are viable for the future? If the government asks us to rebuild Rosebridge Manor to meet new standards, how is it possible without a capital renewal program and financing—capital and financing that have been and are being provided to other homes but withheld, we feel, from ours? What assurances are there that the home will remain in the community that it currently serves?

Why are residents in our home treated differently from those in newer homes? My father fought to preserve our way of life and to ensure that all Canadian citizens would be treated equally, provided the same opportunity to live their lives with dignity and respect. This bill seems to fly in the face of this by giving some homes more support than others. Is the government saying that my father has become a second-class citizen? I certainly hope not. The age of our home does not make it a less desirable place to live. In fact, with support equal to that given to newer homes, it would continue to be a place where my father and the loved ones of others could spend their days in peace, surrounded by fresh air, in a country setting similar to what most of the residents grew up in.

Our residents, families, staff and communities need more than Bill 140—I always want to put a “C” in front

of that from the old federal thing—currently provides. We ask this committee to address our concerns. Remove the uncertainty that Bill 140 creates about the future of Rosebridge Manor. The people in our home are the working people who grew this country into what it is today. Ensure that our 78 residents benefit from equal funding and capital renewal programs that are now available to newer homes.

In addition, on a personal note, Bill 140 currently provides 195 places to introduce new regulations. More rules and regulations imply more paperwork and more processes. This results in less time for staff to care for residents. Does the government want more paperwork or more care? Please take a look at the total picture when you are thinking about more regulations and assess what you are asking of the staff that we count on to look after our loved ones. One thing that I always found in the federal public service was that when we put out regulations from headquarters, from the central body, and we asked the regional people to do newer, different or more things, we had to make sure first of all that there was the staff there to do it and that they could actually accomplish this within the time we wanted them to do it. I'm not sure that with this many regulations we can put the thought into that. We have to proceed very carefully, I feel, with those kinds of things.

Provide assurance to the public that they will have access to long-term care in their community in the future.

Bring our forefathers into the forefront. It is what they need from you and is surely what they deserve.

1000

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We can divide it equally among the three parties.

**Mrs. Witmer:** Thank you very much for your presentation. I think you've articulated very well the concern that many people in small communities throughout the province of Ontario have, and that is the uncertainty as to whether that small home will actually survive into the future, because there is no capital or renewal plan to improve those C and B beds, and obviously, with the limited licensing, you don't know whether you're going to be here seven or 10 years from now. So I hope the government does hear you; I hope they hear others. I have heard from people in small communities—I grew up in one. They're afraid that home might not be there and maybe they'll have to go to Kingston or Brockville or London or what have you. There is that level of uncertainty here.

I think you've made a really good point: When you introduce regulations, you also need to take into consideration the additional time that is going to be required to implement them and the impact on staff, and that's not here. We know there already is not enough money to provide the level of care that's needed for the people in the homes, so the government does need to step up to the plate.

I really do thank you for your presentation. You've made a good point: How do you feel paying the same

amount of money for your bed and your home as someone who's in a new home, an A-bed level of care? How does that make you feel? It does create two levels of people.

**Mr. Kent:** That's why I'm here. When we first brought my father to Rosebridge, three and a half years ago, it was on an interim basis because we wanted to get him into a larger place in town. Once he was there for a couple of months, because the care is so exceptional and because of the setting of the home and this type of thing, we decided we just couldn't move him away from there because we were so happy with the home itself. So it's a bit of a trip for us, a 40-minute trip, to go to Rosebridge, but when you have these smaller homes in a country setting like that, I think they deserve to have the same kind of funding levels as all the other homes. We're not creating different levels of residents, I hope, in this thing, that because you're in a newer home, you're a different class of person than somebody who's in an older home.

**The Vice-Chair:** Thank you. Ms. Martel.

**Ms. Martel:** Thank you for your presentation here today. Mr. Kent, thank you for your many years of public service.

I wanted to actually talk about licences. I note that you've got four-bed wards and a large dining room, so sooner or later you're going to be asked to make some changes and to move to two-beds and perhaps a change in the dining room. Explain to me again what your concern is with respect to having a fixed licence and, within that fixed licence, conditions around a redevelopment, going to the bank or credit union and trying to borrow money with the knowledge that there is no capital program in place to support what you want to do. Express to me your concerns, in terms of uncertainty but also financing and costs.

**Mrs. Hobbs:** I think Fraser Wilson explained that fairly well, and I would defer to his answer. I think it is related to, if we can't say that we are going to be operating for sure in 10 years, we will not be able to get any sort of renewal on our mortgages. I don't believe that any financial institution is going to loan money for improvements or anything else if our licence is not firm. Right now, our licence is based on performance: how we meet standards, that sort of thing. There is not that sort of guarantee in the new bill for licensing. We don't know how our licence is going to be determined. That's the concern.

**The Vice-Chair:** Thank you. Parliamentary assistant.

**Ms. Smith:** Thank you for being here. Thank you for donating your time to the family council. We really appreciate the work that family councils do and we've tried to give them as much support as we can through this legislation.

Rosebridge Manor is part of the OMNI chain, so you haven't actually been impacted by the licensing scheme in the sale process that's going on; I think Fraser spoke to that earlier.

I just wanted to ask Mr. Kent, with his past experience on drafting legislation at the federal level, it would be

unusual to include a redevelopment plan in legislation that was a timely—as the previous government did in their D-redevelopment plan, that was not in legislation. That would be more of a budgetary question, would it not?

**Mr. Kent:** It's a bit hard for me to comment on that. All my legislation was centred around customs and enforcement-type legislation. I really couldn't comment fairly on that.

**Ms. Smith:** But if in the customs area you were looking at refurbishing the customs offices across the country, that wouldn't be in legislation; that would be a budgetary question and a policy question for your department, right?

**Mr. Kent:** That's correct, yes.

**Ms. Smith:** So it would be unusual to put a redevelopment plan in legislation because usually it's a fairly time-sensitive, one-time deal. The legislation, we hope, will be around for some time to come.

**Mr. Kent:** Yes. If we put funding out to all the regional offices, there would be some regional offices who would really complain if they got a lot less funding than some others.

**Ms. Smith:** And if that was locked in legislation, they'd be complaining for a long time.

**Mr. Kent:** Yes, they would. I'm very sure of it.

**The Vice-Chair:** Thank you.

## PROVIDENCE CONTINUING CARE CENTRE

**The Vice-Chair:** The next presentation will be by Providence Continuing Care Centre. Welcome. You can start when you're ready.

**Mr. Larry Norman:** Good morning. I want to thank you for the opportunity for coming here and speaking to you this morning. I'm Larry Norman; I'm chair of the board of the Providence Continuing Care Centre. I have with me Shelagh Nowlan, who's the administrator for Providence Manor.

Let me start by saying that Providence Manor is part of the Providence Continuing Care Centre, which constitutes St. Mary's, a rehab chronic care hospital, and also Mental Health Services, which is the former provincial psychiatric hospital. We run those facilities, so I might come at this from a slightly different perspective.

Providence Manor is a charitable home for the aged. Of the 243 residents we have at the moment, five are designated veterans' beds. It's the only Roman Catholic-designated home in southeastern Ontario, but I want to stress that it's open to all faiths. It has 150 years of history of administering to those who are vulnerable in the community and often disadvantaged.

I want to say, first of all, that we are not against Bill 140, and we welcome many of the aspects of that. But like any legislation, it can always be improved by talking to those people who are engaged in the system and who see the issues day in and day out. We speak from the perspective of the non-profit sector, and I'll focus on a few issues.



But before I do that, I want to talk generically about a few issues. First of all, this is part of a holistic, integrated system. It is not independent by itself. We live in the province of Ontario, where many of us will be borne into the health care system through a hospital or something, and we'll spend our last days being supported by this province in our homes or in a long-term-care facility or in a hospital. In between, we'll use the facilities as needed. I say that because it's important that we don't look at legislation as separate from the whole. It is very much an integrated system. If you don't believe that, all you had to do was listen to the CBC or read the newspapers last week about our friends at KGH, who have no beds for those who need them because there is no long-term-care facility. So I ask you to think about the holistic nature of this system in which we are engaged.

The second thing generically I want to say is about funding—and I'll speak more specifically later—but just having the absolute money at some point in time through the calendar year is insufficient. We lobbied hard for multi-year funding commitments in the hospital system, and the benefits of that are enormous. I speak as the chair of the board for hospitals. They must move to the same kind of thing for long-term-care facilities. My background, I guess, is in business. I don't know how you can run a business—and this is a business, although it is a not-for-profit business—without having the ability to plan in more than a one-year or six-month time frame.

With that being said, let me move on to some specifics about the bill. First of all, not-for-profit care delivery: I believe that we must, in this legislation, enshrine the rights and specifically the notion of "Not-for-profit is here to stay." I have a concern about that because it is eroding, and I'll give you a specific example of that. As you know, we have a shortage of long-term-care beds in this community and we recently had an RFP to make a proposal. We have chosen not to submit. There is no way that we could fund a new facility. We have no profits; we'd have to borrow the money and then have to get it back some way by saving here and saving there. Sometimes I feel like master of the house in Les Miz: You save a little here and a little there and a little somewhere else and maybe you can make this thing come together. But that's really being facetious, and I don't think I want to go there.

**1010**

So it's important that we do enshrine this in the legislation. It is in other parts of legislation in the health care system; why not here? I think it's important because we as a non-profit organization, and being a religious organization, have a long history of care in this area. As a matter of fact, our waiting list of people who would like to get into our home exceeds what we could ever, I suppose, look after in the next 10 years.

Let me now move to the fixed-term licensing. I sometimes wonder when I read this if this not a pipe dream, in a way. Let me ask you this: If you were to come to me today and say, "We're not going to renew your licence"—I have 250 beds approximately—where would

these people go? What would you do? We already don't have enough, so I wonder how you really would make something like this work. Maybe what we need to do is put more emphasis into making sure we never reach that point and put the energy into that place where we'll have good, viable institutions so that we will never have to face a renewal of licence.

There's another aspect of the renewal of licence I do want to talk about and that is, there are two aspects to a facility. One is the operating side of the coin; the other, though, is the maintaining side of the coin. To keep the facilities renewed and vigorous and right for the residents that we have in these institutions, we have no means of capital money except what we can find somewhere to keep these systems—as an example, we just borrowed \$1 million from the bank to make sure the windows were renewed, the roof was renewed and all that. We'll pay that back somehow, some way; maybe through our local foundation, maybe by saving a little here and a little there. But is that really what we want? We need to have some kind of a capital, as we do in the other aspects of the hospital system. When I go to St. Mary's, I've now got monies. They may or may not be adequate, and we can debate that, but at least there's money every year that I know I can use for this kind of thing—absolutely critical to do that.

Let me talk about regulations and cost, and I want to come at this from the point of view of, how much money do we have to do this kind of thing? Being part of a larger hospital system, we have scorecards in place, we have many of these standards in place, but I would bet you this morning that they would not meet what you will put in place in terms of how they're formatted, the right computer programs and all of that. But they do exist, and the question is, how much are we prepared to spend to do that? And with the absence of long-term funding and adequate funding, they will take away from patient care. You've heard that many times this morning, and I heard that as I sat there too. So it's an important thing to think about how we implement this. I don't discount the importance of standards in the system. We all have those in our lives and they need to be there. But what's the cost and how do we cover the cost of that and do that?

Let me talk a little bit about the personal liability of directors, because I guess I'm sensitive to that. I'm not sure anymore which one I now come under in this act, because for me personally, what I'm entitled to or not entitled to under this act is different than if I was at St. Mary's or Mental Health Services. So we need to be thoughtful, and that gets back to my point about the integration. These things should not stand alone. Should they not be part of a bigger whole and should we not be consistent? I wish I was working for Ontario Hydro, where if I screwed up I might be able to walk away with a little more money than I would as a director. But I have to tell you this: I spend time every day in this health care system. As a volunteer, I get nothing out of this except that I'm doing some good in this community and making a difference, and that's important. And it's important to

me. But to come out and then jeopardize people like me who are prepared to give time to do this I think is inexcusable. There has to be a better way of doing this than what is currently proposed.

Because I'm sure you have some questions, let me conclude by saying thank you. I hope you can make some changes.

I've been involved in this health care system for some 30 years as a volunteer and maybe 25 in the long-term-care field. This is a very, very dynamic and changing world we live in. It's important that we don't enshrine in legislation a whole bunch of detail and standards and so on which will be different two years or five years from now. Legislation changes but slowly and rarely. I ask you and plead with you not to do too much of this kind of thing. It is important to have standards, but every home is different. The residents we have today will be different than they are five years from now. Those standards put in place today, will they be the same five years from now? I very much doubt it.

When I was first involved with Providence Manor, people who came to that community could walk downtown; they could do things. Sure, they needed help and needed care. Today, there's nobody who can walk downtown and there's nobody who doesn't need extensive care, and that will be different five and 10 years from now. So I plead with you, whatever you do, take the future into account. It is not a today issue; it's a longer-term issue than that. Somehow we got mixed up: "Because we have a bit of a problem today, we'll put in legislation that's only good for today but not good five or 10 years from now."

I close with that note: Please think carefully about what you do. Thank you.

*[Interruption.]*

**The Vice-Chair:** Thank you very much. We have about three minutes left. We can divide them equally between the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation and frankly for your commitment to the health care system.

I want to focus on your concerns about licence renewal because you said that you have existing financial obligations that extend beyond what would probably be a 15-year licence under the provisions and also that indications from the lending community are that this would increase the cost. Have you had those discussions with your financier? Is that what you're being told directly about the implications for you if the bill is passed in its current state?

**Ms. Shelagh Nowlan:** At this point, not directly. We haven't had to go to seek further financing. We have just recently acquired a loan through the existing options. But the indication is that shorter-term licences, as I think shorter-term mortgages do, have increased repayment schedules. That's the focus that we were bringing to this discussion.

**The Vice-Chair:** The parliamentary assistant.

**Ms. Smith:** Thank you for your contribution to health care in the community and your personal contribution

over the years. I know that Providence does a great job. My brother was a med student here; he did geriatric care and spent some time with you a while back.

I wanted to ask you about your concerns around the regulation and the documentation. We've asked this a couple of times of providers, and this may be more a question for Shelagh. Can you point out to me which sections of the act you feel will be requiring more time than what is already in the policy manual, in your practice manual, in the regulations and in the legislation as they exist now?

**Ms. Nowlan:** Certainly. The documentation that I am referring to specifically refers to some of the added frequency and description of what a complaint is. There is an increased burden to not just look at the written complaint but to look at complaint processes, which often are managed within the home itself—the resolution of issues is best dealt with promptly, working with the resident and family. What this does is add a layer to the reporting structure. At Providence Manor, we also currently report to the board through, as Larry had mentioned, reporting schedules on risk issues—

**The Vice-Chair:** Thank you. Ms. Witmer.

**Mrs. Witmer:** Thank you very much, Mr. Norman. What an incredible record of service. I would have to say, your presentation just made a lot of good common sense. I think the audience recognized that and applauded it. I do thank you very much.

You said that the RFP process for the new beds here in Kingston—which I know are desperately needed and I understand now they aren't going to be ready until 2009 or beyond—was a disadvantage to you. You couldn't even participate. Can you just expand on why you couldn't?

**Mr. Norman:** Two reasons: One is that we have no capital available, so we would have to borrow the monies. That's the first thing. Second, we did do some work, and we could not build for the dollar-per-square-foot value that was given to us. We checked that with a couple of architects and so on. We could not do that. However, we have agreed to work with some others who might have an interest in helping because we do have a lot of expertise in this field. We are prepared to work with others to do that, and we've made that commitment.

**The Vice-Chair:** Thank you very much for your presentation.

1020

#### SHERWOOD PARK MANOR

**The Vice-Chair:** Now we'll move to the next presentation, which will be by Sherwood Park Manor.

Welcome, sir. You can start whenever you're ready, but before you do, please state your name and the name of your company.

**Mr. Jack Butt:** Thank you, Mr. Chair. My name is Jack Butt. I'm the chairman of the foundation at Sherwood Park Manor. I'm pleased to be joined by two of my colleagues: Ms. Joan Bennett, our administrator, and Dr.



John Southin, who was a former chair of our board and is currently the chair of our public relations committee.

Sherwood Park Manor is a full-service, accredited, non-profit nursing home. We opened our doors in 1976, and today the manor is one of a few fully accredited nursing homes in our area. We have 107 beds and 106 staff. We strive to ensure that the atmosphere is conducive to the dignity and well-being of our residents. We pay careful attention to each and every aspect of our residents' daily lives so that they can truly say, "This is my home."

As a not-for-profit charitable organization, we rely on private donations, our foundation and in-memoriam gifts to fund the replacement of furnishings and equipment. This differs from municipal homes that can access levies from municipalities and, similarly, private homes where profits could be redirected towards immediate needs.

Our board supports many of the aspects of this legislation, and both our administrator and director of nursing can attest that they have struggled to achieve much of what is being contemplated in Bill 140. Our staff and our board very clearly endorse the notion of building a strong and safe long-term-care system, and we understand and support the need for constant monitoring, the need for high standards and the need to strive for improvement. That notwithstanding, our board is concerned that this legislation in its present format will not encourage partnerships, is prescriptive and will have a serious impact upon the delivery of our care.

We hope that you all take time to re-evaluate this legislation and once again affirm the government's "commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all ... residents."

At Sherwood Park, we value the input and advice we receive from our residents' council and our family council. You should know that we have worked hard to create this positive climate that fosters open dialogue and nurtures good relationships with our residents and their families. In fact, we actively engage all our residents and our families in their plan of care and the overall activities of the manor.

We believe that the current balanced approach that we have developed will, with this legislation, place us in conflict with our residents. Our director of nursing asks the following: "How do I now deal with a resident who refuses infection control and then puts others at risk?" Further, she asks us, "What about a resident who refuses baths and refuses to participate in normal personal hygiene, yet asks to be seated at a dining room table with others?" We are also concerned about this contract between the resident and the home which allows these individual rights to be enforced at the risk of infringing on the collective rights of others.

Further, we suggest that if members of our community at large have access to all our budget information, then the process of collective bargaining would be fatally compromised.

We do support the provisions of the act that minimize restraints. However, once again the act requires documentation by registered staff, as those impacted have to be monitored every two hours; once again, a funding issue.

Our director of nursing has significant concerns around psycho-geriatric transfers in our community as beds are being downsized at another facility and those residents or clients then being intermingled with our other residents who are frail and elderly.

Our director of nursing also tells us that we are more regulated than any other sector, particularly the hospitals. She tells me that this new legislation already makes significant impediments to her ability to recruit and retain staff. The complexity of care required in our sector requires special expertise, and the increased workload under this bill, without increased funding, means heavier workloads. It means more resignations and greater challenges in recruitment. It follows that her staff will be unable to measure outcomes and therefore provide effective service delivery, as we believe what gets measured gets done. A law of nature suggests that resident care will suffer as our staff devote their time and resources to the preparation of reports and other documentation.

Certainly we endorse the concept of the enforcement of standards and accountability. However, once again we suggest to you that funding must be increased to ensure that compliance documentation is not only completed thoroughly, but is taken seriously.

As well, our board is very concerned about the added obligations and the penalty provisions under this act. We have been advised that our directors' and liability insurance will not cover anything we have to do by law. For example, it will not cover fines levied under the act, and we suspect that it will be difficult for us not only to retain but to recruit board members. In fact, one of our board members who is a lawyer has already written Minister Smitherman in this regard, and I suspect that in his concerns and his articulation of them, he is speaking for every board member in Ontario.

In preparing and reviewing our comments for this act, we had access to a 2001 report from PricewaterhouseCoopers and also a recently released coroner's report that made some 85 recommendations. Both of those included an articulation of the need for increased funding and minimum standards. We have since learned that that position is also supported by CUPE and OPSEU.

Sherwood Park Manor, along with other homes, has a long history—and a proud history, I might add—of going that extra mile for residents, often providing more than is required by topping up provincial funding with donations from our foundation, by creating home-like environments, by serving the distinct needs of our communities and working with a cadre of volunteers. We recognize the need to continue to play a leadership role by providing quality care, and we wish to continue our partnership with the government to make important and lasting improvements. Unfortunately, we perceive this bill to be adversarial in nature, as it will impose addi-

tional and substantial hardships due to new requirements which we'll have to meet.

1030

We perceive that many of the sections of this act are flawed and need to be revised. Our board has asked me to tell you that they would be supportive of the creation of a task force which would be representative of all our stakeholders. They suggest that this task force be assigned the challenge and responsibility of developing practical, workable and palatable compromises and solutions which would result in not only achieving the government's objective of higher standards but would also have the commitment and support of all the stakeholders.

We agree that we can't erode the current level of care. We agree that we must be accountable and responsible. We believe in partnerships. We believe that bad apples must be punished. We also agree that good performance must be rewarded.

I think it was Mark Twain who said, "If your only tool is a hammer, then all your problems are nails."

Thank you for the opportunity to talk to you.

**The Vice-Chair:** We have a few minutes left. We can divide the time equally among the three parties. We'll start with the parliamentary assistant.

**Ms. Smith:** Thank you, Mr. Butt, and all of you, for being here from Sherwood Park Manor. We appreciate hearing your views.

I've heard concerns around the involvement of community members on family councils, so I appreciate you raising that with us again today.

I wanted to ask you a quick question about removing secure units from the more intense monitoring and documentation around the use of restraints. Why would you feel that residents who are living in secure units would require less monitoring with the use of restraints than those living in the rest of the home?

**Mrs. Joan Bennett:** Perhaps I could respond to that. It's rather a broad issue, so I'll answer it in a broad way. There's quite a lot of pressure right now for us to accept residents who have a psychiatric diagnosis, and there are a lot of reasons for that. The access to chronic psychiatric beds in our community has decreased, so there's a lot of pressure to take people who have a psychiatric diagnosis. Very often their behaviour is difficult to control and they're a danger to other residents. But we do take them. We have a lot of expertise in that area. We've found that 92% of our residents have psychiatric diagnoses. To a large extent, we're able to manage them, but fairly frequently we have residents who develop violent behaviours, who are a danger to other residents, so then what do we do? We try to have them transferred to the psychiatric hospital, but they don't have chronic psychiatric beds. So what we have done in the past is transferred them to the secure units, but now that's very hard. Under this bill, they can only be transferred to the secure unit if that person's decision-maker agrees. That's my understanding from the Ontario Association of Non-Profit Homes and Services for Seniors.

**The Vice-Chair:** Thank you.

**Ms. Smith:** We can talk about that after, because I don't want to take any more time.

**The Vice-Chair:** Mr. Yakabuski.

**Mr. Yakabuski:** Thank you very much for your excellent presentation.

Picking up on your Mark Twain story, I'm sure everybody here has seen the OLG ad—it used to be OLG, but they changed that for \$6 million—because the government spends a lot of money on advertising, where this hockey team is sent out to play a game of hockey in all this retro equipment and they get quite a shellacking. It's somewhat entertaining. Would you say that that's a fair analogy of what we're expecting our long-term-care homes to accomplish under this bill? We're giving them all kinds of responsibilities and regulations to work under, but we're equipping them like this hockey team that was equipped out of the 1920s to go play against a modern-day team. Are we setting this whole thing up for failure simply because the government wants to send a good political message out there?

**Mr. Butt:** It's our board's position, clearly, that if we impose increased documentation and increased standards and don't provide the corresponding increase in funding, then our staff are going to concentrate not on providing the bedside care that we demand but in filling out forms and documentation, which we think is unacceptable.

**Mr. Yakabuski:** And ultimately that would be bad for our residents.

**The Vice-Chair:** Thank you. Ms. Martel

**Ms. Martel:** Thank you, all of you, for being here. It's nice to see you again, Mr. Butt, albeit in a different capacity this morning.

I want to focus on minimum standards, because my concern has been the fact that there are no minimum standards in this bill, despite the fact that the Liberals promised to reinstate minimum standards in the last election. They said 2.25 hours at that time, but I think it should be closer to 3.5, and there are many others who are in support of that view. Of course, that requires more staff, but if the government also lived up to the second promise that it made in the election, to fund \$6,000 more per resident, then there would be the money available to provide the staff to increase that level of care.

Can you give me a sense of what your level of care is per resident at your current funding levels?

**Mrs. Bennett:** I can answer that. Actually, sadly, this year we've had to cut the hours for health care aides. We've had to cut our hours 10 per day going into this year, because the track of funding in the last three years has been really poor. In nursing, this last year our funding increase was 1.71%; in programs, 2.5%; for raw food, 1.12%; and in other accommodations, which is dietary, maintenance, housekeeping, utilities, insurance, auditing, legal, bank fees, postage, office supplies and mortgage payments, we got 0.88%. Our union—

**The Vice-Chair:** Thank you very much.

**Mrs. Bennett:** Oh, I couldn't answer you. Sorry.

**The Vice-Chair:** Thank you very much.

**Mr. Butt:** Thank you.



## JEAN BERTRAND

**The Vice-Chair:** We'll move to our next presentation, by Caressant Care Nursing Home. You can start whenever you are ready.

**Ms. Jean Bertrand:** Good morning. My name is Jean Bertrand. I am a member of Service Employees International Union. I welcome this opportunity of appearing before Mr. Chair and the standing committee on social policy to discuss the Long-Term Care Homes Act, 2006, Bill 140.

I have been employed for 20 years at Caressant Care Nursing Home, Marmora, Ontario. Caressant Care Nursing Home has a total of 84 long-term-care residents.

Staffing hours for a 24-hour period:

—Day shift: one RN, seven hours; one RPN, seven hours; eight PSWs or health care aides at seven hours, equalling 56 hours;

—Bath shift: one PSW, seven hours;

—Evening shift: one RPN, seven hours; one RN, seven hours; seven PSWs at seven hours, meaning 49 hours;

—Night shift: one RN, seven hours; three PSWs at seven hours, equalling 21 hours.

Total care hours are 168. We have 84 residents, so 168/84 equals two hours of care per resident.

The long-term-care homes in Ontario are understaffed and under pressure. This is why we need a minimum standard of 3.5 hours per day of nursing and personal care for residents. These people are human beings, with the right to be treated as such. We are not factory workers and they are not machines, but this is how both nurses and residents feel. These residents in long-term care built this country. They are our parents or our grandparents. They have had enough hardship in their lifetimes already. Residents have the right to be respected and have dignity. They have the right to live out their golden years in a safe and comfortable environment. Their needs are few, and yet we continue to fail to meet them. Some residents without families need more care time. We are their loved ones or family.

1040

Understaffing is a chronic problem in Ontario nursing homes. Understaffing translates into poor resident care. Most of the time, if some employees call in sick or are absent, we work short. Overtime to remaining staff, some RNs, is for one hour. The home claims that it is not in the nursing budget. One personal support worker takes care of 12 residents at a time. If you are short, then you pick up the other short-staffed residents. In a seven-hour day, a personal support worker helps to feed morning nutrition, to deliver laundry to residents' rooms, full periodontal care, toileting, bathing, grooming, suppository days, shaving etc., making beds, tidying dressers and closets, and making sure that everything is marked with names. The nursing home demands that a resident's diaper be 80% wet before we change one diaper in a seven-hour period. Staff need to cope with ringing call

bells, wandering residents, doctors' days, blood days and lab days, and sick residents take even more attention.

To get CMI, you have to chart. Who has the time? We work understaffed with full-time staff, and when we work short, then there's stress, sickness, WSIB, loss of time. That is why we have to put the staffing standard at 3.5 hours per day of nursing and personal care per resident. I have been employed in this sector for 20 years, and these residents need these hours for living in dignity and with respect, safely and comfortably.

Bill 140 is a flawed piece of legislation reflecting the betrayal by this government of the people of Ontario, betrayal of the wishes and needs of our seniors and the people who provide quality care in facilities across this province. The sad state of long-term care in our province is that the provincial Liberal government has an obligation to show leadership in dealing with this situation. You cannot have quality care without people. To this end, a staffing standard is a necessary first step. A necessary second step is for the Liberal government to commit itself to the non-profit model, then to the state of long-term care. Taken together, these will ensure that people living in this province will have access in their communities to the kinds of services they need now and in the future, services provided for them by dedicated, qualified staff who themselves are members of the same communities.

If Bill 140 is not amended by this government to deal with a staffing standard of 3.5 hours per resident per day and a non-profit model, then the state of long-term care in our province will not improve. We urge the Dalton McGuinty government to address the issues I have raised in my presentation. We further urge them to listen to the concerns of the people in Ontario and act upon them.

Thank you for the opportunity of appearing before the standing committee on social policy to share my thoughts regarding the Long-Term Care Homes Act, Bill 140.

**The Vice-Chair:** Thank you very much. We have six minutes left, which we can divide equally among the three parties. We'll start with Mrs Witmer.

**Mrs. Witmer:** It's always very refreshing to hear from someone who's personally working with the residents on a day-to-day basis. Certainly when I visit homes I do see the tremendous pressure and stress on the health care providers such as yourself, with the lack of resources.

The Liberals did promise an additional \$6,000 for each resident to provide for personal care. That hasn't been delivered. Now we see a bill that introduces more paperwork and that really, again, is going to lead to a decline.

We've been hearing today that the residents in the long-term-care homes today have much more complex needs than in the past, and I suspect that this is only going to increase. You've said that, for example, a minimum level of 3.5 hours of personal care needs to be provided, as opposed to the current two hours. What is it that you could do for residents with the additional care that you really feel is impacting them negatively today?

**Ms. Bertrand:** My feeling and the feeling, I'm sure, of all nursing staff, PSWs, health care aides and hands-on care people is that we really need to have a little bit more time so the residents don't feel that they're being treated like a machine. You go in there, you say, "Good morning," and that's about it. You have so little time, because you start at 6 a.m. and you have to be in the dining room for 8 o'clock. That's unfeasible. You have 14 residents to wash or bathe and care for before breakfast.

**The Vice-Chair:** Thank you. Ms. Martel.

**Ms. Martel:** Thank you for your presentation and for your work in this sector over many years caring for the frail and elderly. Tell me, in those 20 years, what has been the change in the health of those residents who are coming into your home now?

**Ms. Bertrand:** I find that the thing with CMI is you get more points, you get more hours, for your hands-on care, but if you don't have time to document—which we don't, because we're so overworked. We don't have time to document to improve our hours.

**Ms. Martel:** If someone calls in sick, if someone gets ill or gets hurt and has to go home, is the home replacing the staff? Or is the first line, essentially, to just ask others to do more?

**Ms. Bertrand:** Because the workload is so heavy in the nursing home, it is very hard to keep new staff. They just can't cope with the hours and what you have to do in a short period of time.

**The Vice-Chair:** Thank you very much. Parliamentary assistant.

**Ms. Smith:** Thanks for being here today. In my tour of a variety of homes a couple of years ago, I didn't get to Cobden, but I did get to Marianhill and Bonnechere Manor and Deep River—so a few in your neck of the woods. I appreciate the great care that you're giving to the residents in your area.

I wanted to ask you a bit about the staffing standard that you've been talking about and the 3.5. There's a lot of discussion around that issue and a lot of discussion about what is included in that 3.5. Would you include in the number the hands-on caregivers, would you include dietary and restorative care, and would you include people who are doing activities with the residents?

**Ms. Bertrand:** No, just hands-on care.

**Ms. Smith:** How do you define hands-on care?

**Ms. Bertrand:** Hands-on care is somebody who really takes care of you completely—total nursing care.

**Ms. Smith:** So the nursing aides, the personal support workers, the RNs and RPNs?

**Ms. Bertrand:** Yes.

**Ms. Smith:** What about people who come in to provide physiotherapy or occupational therapy? Would those be included?

**Ms. Bertrand:** Definitely not. I'm just speaking about the hands-on care, because these people really do need it—and not to be washed in a matter of seven seconds.

**The Vice-Chair:** Thank you very much for your presentation.

1050

## ST. PATRICK'S HOME OF OTTAWA INC.

**The Vice-Chair:** We'll move to the next presentation by St. Patrick's Home of Ottawa Inc. Welcome to the standing committee on social policy. If you don't mind, before you start, please state your name and your colleague's name.

**Ms. Linda Chaplin:** Good morning, Mr. Chairman and ladies and gentlemen. My name is Linda Chaplin. I'm the executive director at St. Patrick's Home in Ottawa, and with me is our board chair, Mary Whelan.

St. Patrick's Home in Ottawa was founded as a children's orphanage and a house of refuge for the elderly in 1865, which was two years before Confederation, of course. It's one of the oldest in Ontario. Our current site was built in 1964, with an addition in 1985. The Grey Sisters of the Immaculate Conception operated St. Patrick's from 1933 until 1996. At that point, the home was incorporated as an independent entity. In the year 2000, the Grey Sisters transferred sponsorship to the Catholic Health Corp. of Ontario. Pending Bill 140's proclamation, we are currently regulated under the Charitable Institutions Act and well served by a voluntary board of directors, who certainly exercise due diligence and care in their governance.

In addition to our 202 long-stay beds, we have an on-site day program and four independent-living suites, supply Meals on Wheels to a community group and are home to 16 Grey Sisters, who have a convent on our fourth floor. Their culture of caring and compassion is perpetuated by their presence, and they make daily contributions to the lives of our residents. We also have over 250 volunteers, who offer much-needed support, companionship and links to our community. The administrator in me calculates their actual contribution as amounting to about 16 or 17 full-time positions.

I welcome the opportunity to present to you today on Bill 140. We appreciate that it intends the assurance of a safe and healthy long-term-care environment and consolidates the statutes that currently govern us. The perspective that I bring today comes partly from being part of a faith-based organization that is known and respected for its long history of loving and compassionate care. We live our core values on a daily basis: sacredness of life, growth and vision, spirituality, hospitality and social justice.

In moving forward with the legislation, we hope the committee will consider our concerns, our comments and also some suggestions that we'll bring forward. Our concerns are driven by the following long-term-care realities, and a number of my colleagues who have spoken have brought these forward as well:

—Our resident profile in long-term care has changed markedly even over the past decade. People coming to us are older, they are more frail, they are much more likely to have cognitive impairments, and overall they have much more complex and heavier care needs.



—More than 50% of our residents suffer from varying forms and degrees of dementia.

—Residents and their families have escalating consumer expectations around care and services.

—The increasingly complex residents in our care, on average, have five or more medical diagnoses, and they receive at least nine medications throughout the day.

—Most aspects of daily care, such as bathing, toileting and dining, require the assistance of one or more caregivers as well as lifting and transfer devices.

—Some residents are resistive to care, and some residents are openly combative.

—It is fair to state that all are fragile and all are in a state of decline.

Bill 140 only marginally recognizes the implications of this reality in our daily interactions with residents, and often their family dynamics are quite complex.

I'll address our concerns under 10 major headings.

Our first comment is on the mission statement. Bill 140 requires that a new mission statement be developed consistent with the resident bill of rights and in concert with resident and family council, staff and volunteers. Our concern is that the membership in councils, staff and volunteers change over time, and each person brings individual belief systems, values, motivations and agendas. Faith-based organizations have a long-standing history of operating within mission statements that are time-tested and reflect their teachings, and they are regularly revisited for currency and relevance.

We are proposing that the legislation include a clear indication that organizations need not include provisions that are contrary to their spiritual foundations and religious teachings.

With respect to boards of directors, Bill 140 gives the impression that voluntary boards of directors have lacked accountability. If implemented as scripted, the bill will represent an onerous, if not impossible, challenge for recruitment and retention of voluntary directors. The possibility of personal liability and individual directors being held accountable if they "fail to take all reasonable care to ensure their homes meet all the requirements of the act" with fines of up to \$25,000 or 12 months in jail is a significant deterrent. This leads to the high probability of insurance premiums increasing and that, potentially, policies will be more difficult to obtain. Without considerable increased funding to implement Bill 140, we will experience a negative impact on an already strained capacity for front-line care delivery as further resources will be redirected to meet the new standards and avoid repercussions and penalties.

We propose that the framework in place within the Public Hospitals Act be utilized as a reasonable guideline for expectations of our voluntary boards. There are certainly general offence provisions within the Public Hospitals Act, but the penalties range from \$50 to not more than \$1,000 on conviction—significantly different from \$25,000 and 12-month jail terms.

With respect to the plan of care—this has to do with the documentation issue that a number of my colleagues

have spoken to. We certainly are respectful of the fact that each resident deserves individualized care. Certainly, both the sector and our residents have benefited from the standardization that was implemented in 1993. However, on surveying both our medical director and attending physicians, they feel that the documentation burden will become prohibitive due to the significant opportunities for inspections outlined in Bill 140. We are already highly regulated, inspected and legislated, and a further increase is likely to lead to a regretful exit of our current capable and committed physicians.

The documentation burden, however, applies to all professionals in the sector. We work closely with and develop trusting relationships and very solid communications with our families and residents, and we do develop comprehensive, dynamic care plans that are modified as care needs change. The documentation and administrative burden of Bill 140 without resources to deal with it will mean a reduction in front-line care and services. Long-term care in Ontario is already a resource-constrained health environment, with among the lowest funded hours in Canada. Funding has simply not kept up to increasing care levels and escalating consumer expectations. Our priority is hands-on care, and diversion of energies for documentation will compromise care further.

We recommend that a detailed analysis be undertaken to assess the impact of and the need for increased documentation prior to implementation, and ministry commitment to fund the implementation of Bill 140 is essential. We believe ministry funding for the long-term-care sector needs to reflect the actual care requirements and demands.

With respect to consent, Ottawa is one of the areas in the province identified as underserved for long-stay beds, and thus we frequently have alternate-level-of-care transfers from acute-care for whom we are not the first choice. On any one day in the city of Ottawa, there are at least 110 acute-care beds being occupied by individuals awaiting placement in long-term care. There are reports in the province of applicants being dispatched to placements almost 100 kilometres away from family in a facility not of their choice. We believe this must stop. Therefore, we applaud section 42, requiring consent for admission to a specific home.

The area that causes us concern is the requirement for consent for admission to a secure unit. Admission to a secure unit is certainly an emotionally charged decision. The requirement for formal consent is problematic, however, from a risk management perspective, as it can cause delays and resultant risks. We already assess residents' condition and behaviours, and our well-trained staff assess capacity and competence. Families also have access to an external assessment on request.

#### 1100

Because we live in congregate living environments, we must take absolute care for the safety of all residents and all staff. If we have an additional layer of bureaucracy, in the person of a rights adviser, for example, the

timeliness of transfer and safety of all concerned will be impacted and costs will be driven upward as well.

We recommend that if there are homes identified where, for convenience or ease of management, residents are being improperly placed in secure areas, then we respectfully ask that the ministry's compliance division deal with them directly. The vast majority of long-term-care facilities manage transfers to secure areas appropriately and should be permitted to continue to dialogue with our clients and manage the risks associated with a resident's condition.

Similarly, if there are systemic pressures and hospitals and CCACs sometimes discharge to inappropriate placements, this unsafe practice cannot continue, and we ask that it be dealt with through other avenues.

With respect to mandatory reporting, our employees are not abusive, they are not neglectful and they are not incompetent. On the contrary, they are accountable, they value their careers and their reputations, and equally as important, they value the dignity of each resident. Mandatory reporting and the negativity of a blame game does not improve our system. Many families of residents offer loving support, but some can also provide significant challenges if there's a lack of family unity or if they're carrying a history of guilt, anger or unfinished business. Facility employees are often expected to absorb that fallout and somehow cure the flawed family unit. For the same reasons that physicians will choose other options, our workplaces will fail to retain the best staff, and we may be unable to recruit qualified replacements. The highest possible quality care proposed by Bill 140 cannot be achieved if our valuable human resources are lost due to the imposition of rigid rules and punishment. We recommend that the tone of Bill 140 be modified to reflect a respectful approach, with emphasis on quality improvement and recognition for performance.

With respect to the resident bill of rights, Bill 140 sets up unreasonable expectations of long-term-care homes by entrenching the bill of rights in legislation. However, there's no corresponding requirement that resident decision-making capacity or competence be confirmed. There are no corresponding responsibilities of residents or their representatives either to fellow residents or toward staff.

There was a recent Stats Canada survey on the work and health of nurses, and it clearly showed a high rate of stress-induced mental and physical health issues associated with patient assault on nurses.

Licences are of issue to us. We are a C-level home. Portions of our facility are clearly below a C, with three- and four-bed wards. Some of our folks go across the hall to a bathroom. We ask that consideration be given so that our folks have the right to access the same level of comfort and service as residents of A-level homes.

A 10-year licence moratorium and a potential to be advised at seven years is problematic for us. We recommend that budget allocations and licence restrictions be examined and that ministry incentives be applied to support C-level homes.

I'd like to close with a final recommendation that I believe would make a difference on the ground, and that is that the Ministry of Health and our elected officials offer consideration to the positive impact that the not-for-profit sector is already making, that the balance be maintained between the for-profits and the not-for-profits, and that these contributions be acknowledged in the legislation.

**The Vice-Chair:** Thank you very much for your presentation. There's no time left.

#### HILLTOP MANOR

**The Vice-Chair:** The next presentation will be by Hilltop Manor nursing home. Welcome. You can start whenever you're ready. Before you start, please state your name and your colleague's name for the record.

**Ms. Dianne Mason:** My name is Dianne Mason. With me today is Bernard Bouchard, administrator of Hilltop Manor. Thank you for this opportunity to comment on Bill 140.

I'm president of Hilltop Manor, a family-owned and operated long-term-care home. I also serve as a board member of the Merrickville District Community Health Centre. My parents, Oscar and Rose Fader, started our family business, Hilltop Manor, in the village of Merrickville in 1963 with 28 residents in the historic Harry McLean House. At the age of 16, my brother and I began working in the home with our parents. As a family home, we all worked to care for our residents. We considered our residents as our extended family.

Given the increasing care levels and needs of our residents over the 10 years we were in the Manor house, it was apparent that the physical structure was in need of improvement. With the passing of the Nursing Homes Act in 1972, a new building was built and our licence was increased to 60 beds with the provision that we participate in the provincial homes for special care program. We financed the building of the new home by taking out a mortgage. The new Hilltop Manor opened for residents in July 1976. But 31 years ago most of our residents walked into the home, spent little time in their rooms, and some of our residents drove their own cars. The space requirement at that time was suitable. Needless to say, our residents' care needs have once again dramatically changed.

In April 1998, the government introduced new design standards. We were classified as a C home, having eight four-bed wards and limited dining space. In an attempt to meet our growing requirements for space and resident privacy, we requested additional beds and capital funding to once again upgrade Hilltop Manor. All of our requests to the Ministry of Health and Long-Term Care have been denied.

We have continued to provide excellent care to our residents and their families and have been a model employer to our dedicated and caring employees over the past 43 years.



Our home has received ongoing three-year accreditation from the Canadian Council on Health Services Accreditation since 1986, over 20 years. We have enjoyed a positive and productive relationship with the Ministry of Health and Long-Term Care and all of our community partners.

The proposed limited licensing provision of Bill 140, as presented, without a capital renewal program for B and C homes is a serious injustice that will, I believe, lead to the elimination of long-term-care homes in rural Ontario.

I am here today to ask for your support in amending Bill 140 so that Hilltop Manor has the opportunity, after 43 years of exemplary service, to continue providing the excellent care that our residents and families deserve.

Should you decide to keep the limited licensing provisions of Bill 140, as stated, please introduce an appropriate capital renewal program for all B and C homes across Ontario.

**Mr. Bernard Bouchard:** Thank you for this opportunity to comment on Bill 140. I have spent the last 18 years of my work life as a front-line administrator, social worker and advocate for residents and their families, and employees working in long-term care. I have served on the board of directors for the Ontario Association of Social Workers, eastern branch, and as president of the Ontario Long Term Care Association. I continue to work on an ongoing basis with First Nation groups in the development of long-term-care homes and, more recently, have accepted to sit on the collaborative governance development team for the southeast LHINs. I'm looking forward to representing all long-term-care homes in the southeast LHINs. We are at a very important crossroads with the introduction of Bill 140, and I would like to spend the time available on one of the most serious issues before us: the limited licensing provisions of Bill 140.

In support of my colleague's request for an appropriate capital program for B and C homes across the province, it would be reasonable to ask the question: Why is an appropriate capital program for B and C homes needed as part of Bill 140?

Since 1998, we have seen a significant commitment to seniors and their families with the introduction of 20,000 new long-term-care spaces and capital funding. The current government has continued this commitment with the recent announcement of over 1,750 new long-term-care spaces.

As our population ages, these commitments are welcomed by all of us working on the front lines and in our communities. While we support these initiatives, after 43 years of service to our community in Merrickville and on behalf of our residents, their families and our employees, I ask the question: What will be our role in the long-term-care system, and what will our future be?

In 1998, nine years ago, the government introduced five structural classification categories for all homes in the province. It was determined that there were 16,000

residents living in unsuitable physical buildings designated as D homes. The D homes were those homes that did not meet 1972 standards. The older homes, unlike the B and C homes, did not take out mortgages and upgrade, but remained structurally non-compliant over the years. In order to address these poor physical plants, a new D home program was introduced by the government. This D home program included capital funding of \$10.35 per resident, per day, for 20 years. Most D homes took advantage of this program and are now new homes, with only a few municipal homes that chose to remain as D homes.

#### 1110

From a resident's perspective, it made moral sense to all of us to address the structurally non-compliant homes first. It was always my understanding that once the new homes were built and the structurally non-compliant homes were updated, the B and C homes would be given an opportunity to upgrade to a new design standard. These new design standards would eliminate the four-bed wards and increase the dining and activity spaces. We have been patiently waiting for the last nine years and are still waiting.

There are approximately 35,000 residents currently living in B and C homes today. The introduction of Bill 140 is an opportunity to correct this serious injustice. In your deliberations, please keep in mind the quality of life of those 35,000 residents, many of whom share their bedroom and bathroom with three other heavy-care residents 24 hours a day, seven days a week, 365 days a year. Four-bed ward accommodation for Ontario residents in long-term care should be eliminated over time. Just to repeat myself on that important point: Four-bed ward accommodation for Ontario residents in long-term care should be eliminated over time.

As a care provider, limited licensing without an appropriate capital program for B and C homes will be disastrous. Some of the negative outcomes that we can reasonably expect include the inability of a home to get financing, attracting and keeping long-term employees, ongoing deterioration of our home's physical plant and losing our licence through unrealistic government requests or through an RFP process. It is disappointing that while this legislation took three years to write, it will introduce limited-term operating licences linked solely to the building's structure, without a plan to reassure communities that there will be homes to meet the increasing demand and needs, and that these homes can meet the residents' expectation for privacy and dignity. Without a capital renewal program for B and C homes, sections 100 and 180 of Bill 140 will start the clock of uncertainty ticking. This clock will tick the loudest for the 263 C classified homes, many in small rural communities. Their operators, families, employees and the 27,500 residents will be left wondering what day in the next seven years the ministry will decide to reveal their future.

The solution starts with amending section 180 to provide us with a 15-year-term licence and to empower the government to fund a capital renewal and retrofit

program for B and C homes. These amendments need to be supported by an immediate government commitment to work with the sector to implement such a program over the next 15 years. I know that our association, the Ontario Long Term Care Association, has presented this solution to you in detail. On behalf of Dianne, her mother, Rose, our residents, families and employees of Hilltop Manor in Merrickville, I urge you to give these solutions your full consideration. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We'll start with Ms. Martel. Two minutes, Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I just want to go to the last page, actually, where you say that as a care provider, limited licensing in combination with a lack of a capital program for B and C homes will be disastrous. Those are pretty strong words. Can you elaborate on—I don't know if you've done any work in terms of your own home—what possible financial costs would be required if you had to do upgrades? Maybe you could share that with us, but also why, as the legislation is currently drafted, you're so concerned.

**Mr. Bouchard:** We're concerned because the licence is going to put us on a clock in terms of losing the licence. To use a comparison, if you had a temporary job and you went to get a mortgage for your house, the bank would look at you and say, "Okay, you want a mortgage, that's fine, but you have temporary employment." In some sense I look at the limited licensing as creating more insecurity in the sector, and I think that causes a problem. We've heard from other members who have also said that they had difficulty in getting bank financing.

With respect to your first point, I think that ultimately it's really about the residents in the four-bed wards. I think that's an issue that's been in our sector for a long time. I think anyone who works on the front line realizes that when you're living with three other people in a room, given the care levels and the psycho-geriatric problems that we're seeing, it's a recipe for care disaster.

I feel that the capital program is something that is really required for the residents' privacy and dignity. I really think it's important, as we go forward with this bill, that we're able to introduce an appropriate program so that all residents have an opportunity to have more privacy and dignity.

**The Vice-Chair:** Thank you very much. Parliamentary assistant?

**Ms. Smith:** It's nice to see you again. I just wanted to follow up on some of the comments you made about the redevelopment plan of 1997, the OLTCA, which I know you're involved in, and their position around that. There were 20,000 new beds introduced into the system at that time, as well as an upgrade of some of the D beds. In their submissions to the government in 2004, the OLTCA said:

"With the addition of the 20,000 new long-term-care beds there are now areas of the province that have occupancy issues, while other parts of the province still have long waiting lists. There are efforts and discussions

under way with the government around future supply and demand strategies including 'right sizing' the sector."

What we've done with this legislation through the licensing piece is to try and provide the government with some tools to do some planning. That's just one submission that the OLTCA has made over the years. I could go back to 2003, and again in 2005, when your organization, or the broader organization, has made submissions around the need for planning tools and the need for looking at the sector writ large. What we've heard from most of your members has just been a demand for redevelopment of Bs and Cs, and not a lot of discussion around planning tools or planning for the system. Could you just comment on whether or not you think there's a need for planning the system across the province?

**Mr. Bouchard:** There's no doubt that there is a need for planning tools. But with respect to the occupancy issue, when the 20,000 beds were introduced, there seemed to be some vacancy issues across the province, but those have dried up quite quickly.

Part of the issue around the vacancy was people waiting on lists for certain homes. So for example, in Toronto you might have a long waiting list for people waiting for Baycrest. They don't want to go to a different home; they want to go to a new A home. But if you look at the occupancy rate in the last, close to two years, there's no doubt that the demand has increased. I know in our home the waiting list is quite long, and even in homes around the area. So I don't think that—we're looking at adding more beds, as opposed to moving existing beds; I think the demand is quite strong right now. But you are correct: When the beds first opened, there seemed to be some lulls across the province in places like Niagara Falls and around the Toronto area. It was a function of the waiting lists and people not being prepared to be placed when the time came.

**The Vice-Chair:** Thank you. Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation, Mr. Bouchard. This whole issue of limited licensing—the provisions in Bill 140—have created a lot of uncertainty. I heard this morning that there hasn't been any attempt to work with your association in order to provide some certainty and make some amendments to the legislation, and I know you've made a suggestion here. Do you believe that the recommendation that you are providing would restore some of that certainty?

**Mr. Bouchard:** Well, I think if we have 15 years and we have a capital program, then it will come down to people stepping up to the mark and making those changes that are necessary. Again, initially, our view was that the homes that were structurally noncompliant and were the worst environment should go first, from the residents' perspective. But because there's no capital program for the Bs and Cs, we've been waiting patiently. If someone's given a time limit and they're given the opportunity to make the right choice, they will make the right choice and step up to the mark. I think our members will step up



to the mark and will redevelop. But the plan has to make sense, and I think the key component is the details.

**Mrs. Witmer:** So I guess I hear you saying that obviously, one of the most significant amendments that the government can make is to amend the limited-term licensing. Without it, there are a lot of residences whose future security and staff are at risk.

**Mr. Bouchard:** If I'm a young nurse looking for a job, I'm going to want to work in an A facility, because I'll have a longer career than if I work in a B and C facility that happens to be in year eight of a 10-year term licence.

**The Vice-Chair:** Thank you very much for your presentation, sir.

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#### WENDY HAWTHORNE AND ETIE JAMES

**The Vice-Chair:** The next presentation will be by Wendy Hawthorne. Is Wendy around? Welcome. You can start when you're ready.

**Ms. Wendy Hawthorne:** Good morning, ladies and gentlemen. I would like to start by saying thank you for giving me the opportunity to be here today. My name is Wendy Hawthorne, and with me is Etie James. We are both from Ottawa.

I am a personal support worker and I have been working in long-term care for nine years. The home I work for is a for-profit organization.

I feel that the seniors in long-term care are suffering, not at the hands of the staff, who are hard-working and dedicated, but from the provincial government, which refuses to set a standard for the number of nursing and personal care hours and increase the funding to long-term care in Ontario.

At the home where I work, there are 252 scheduled nursing hours in a 24-hour period. When you divide that by 114, the number of residents residing in the home, you get 2.21 hours a day of nursing care per resident, which is lower than when the Harris government abolished the standard of 2.25 in 1996. If you look at the handout I gave you, I have broken the hours down. Not all the time is hands-on nursing care or, at best, personal care. It shows that our nursing care hours actually calculate in the paid breaks which we are, by law, entitled to take. So when you take away 16.5 hours, you're now down to 235.5 scheduled hours. When you divide that by the number of occupied beds, now we're down to 2.06 hours that the residents get in a 24-hour period, not to mention that there are three meals a day served, there's laundry to put away, a snack to pass, and other miscellaneous little items that are not personal care. So at the end of the day you're down to 1.79 hours of nursing care, or 107 minutes. This is why we need to standardize the number of nursing hours across the board, and increase it to 3.5.

When we are confronted with increased nursing care for residents, i.e., end of life, complex dressing, severe behaviours, we are not given additional staff, and

therefore the time needed to tend to these situations is stolen from the other residents. Is this fair?

A few years ago it was introduced that all residents of long-term care were to get a second bath every week. With this announcement came extra funding to help with the increased workload, sequentially creating new full-time positions at the home where I work. A year later it was time for us to be classified, which led our CMI to decrease, which had a direct effect on our funding to be less, causing those positions to be terminated. But we're still continuing to do the extra bath.

When we work short, we try our very best to do the all the work, but it is not possible. Our director of care and executive director have told us that they expect us to do all baths and regular duties regardless of the number of staff on the floor. We have a difficult time doing our job when we are fully staffed; how it can be expected when we are short?

I have the pleasure to work side by side with some of the most compassionate, exceptional and devoted individuals, who feel they need to work through if not part of their break then the whole thing, just so the residents don't suffer.

I could continue with quotes, numbers and facts that you've already been given or will be given at some point through these hearings. Instead I now want to share with you my reality of the day-to-day life in long-term care and why it is so important that the government set a standard of 3.5 hours for personal and nursing care for our seniors in long-term care.

The home area unit in which I work is home to 32 residents, all of whom have varying degrees of dependence. During the day shift there are two PSWs and one registered staff for 7.5 hours and one PSW for four hours. We, the PSWs, are required to assist these 32 residents to the dining room for 9 a.m. This includes washing, dressing, going to the bathroom, brushing hair and teeth, shaving and makeup. It is a very hard and strenuous task when you consider that some of these people require two or three staff due to behaviours or that they use some type of mechanical transferring device. On a rare day, we can be in the dining room by 9:15, but on most days it tends to be 9:30. Once we do get into the dining room, there are still residents to assist with their meal and help out of the dining room.

There are baths and showers to give, four to five on a day shift, laundry to put away, collation to distribute, repositioning of residents who cannot move themselves and aid to all of those who are in need of assistance with going to the bathroom or anything else they might require. Staff coffee breaks need to be taken at this time as well. It is essential for us to try our best to accomplish all of these tasks in an hour and 30 minutes because staff have to start taking their lunch break at 10:45 in order to be ready for the residents' lunch. During the next hour, the floor has only one PSW, which makes it difficult to accomplish next to anything due to the level of care and assistance the residents need.

At 11:45 we start to help the residents back into the dining room for their lunch. There are now only two

PSWs to serve and assist 32 residents during this meal. We can usually have everything done by about 1:10. At this point in the day, we are returning people to their rooms and helping them to the bathroom or back to bed, whatever they may require. We are supposed to take a break around 2, but don't always have time as we still have to dispose of soiled laundry and do another collation pass and our paperwork, which usually takes 25 minutes alone to do. All these things are taking us away from what I am really there to do, and that is to look after the residents. This government needs to set a standard for the number of nursing hours and it needs to be 3.5.

Do you have any idea how hard it is to tell a family member or a resident that I can't take them to the bathroom because I don't have someone to help me? It's horrible. It makes me sick every day. It's not right, but it occurs, sometimes more than once. But it shouldn't happen at all.

The people who are working in long-term care are burning out due to the overwhelming physical and mental demand this type of work puts on you. The Ontario government needs to step up to the plate to fix this situation and set the standard number of hours.

The population that is coming into long-term care is older, frailer and sicker, with more complex medical problems than individuals 10 to 15 years ago.

I didn't come here today to tell you I'm overworked or complain about the conditions I work under. I came here today to try and make you see what it is really like, and to show you that our mothers, fathers, grandparents, aunts, uncles and spouses living in long-term care deserve more and deserve better.

**Ms. Etie James:** I'm an RPN, in long-term care as well, in a for-profit corporation.

I want you to refer to the PSW assignments that we had to do last year when the two-bath mandate came in. I'm not going to belabour that one; I will just let you look through that. That is one thing in our day that took us quite a lot of time to actually get together.

Briefly, I will attempt to outline life in a long-term-care facility from a registered staff perspective and the difficulties we encounter on a daily basis. The time that the CMI does not account for becomes part of the job. You have a copy of that and I just told you about that. It speaks for itself. There are many time-consuming tasks that eat up our days.

Time spent on doctors' rounds, care conferences, answering phones and making appointments for residents is not accounted for in the CMI.

There is time spent on residents who are: (1) dump-and-runs; (2) psychiatric cases; (3) street people with no families; (4) difficult POAs, often related to number (1); (5) palliative residents; (6) family members associated with number (5); (7) mentally ill family members; (8) quasi-residents who are family members but are there on a daily basis from 8 o'clock to bedtime; (9) immigrant dependants who speak no English; (10) families who don't think they need to do anything and that the home will do it all—including finding clothes for them—are

very demanding and require extensive explanations before doing anything requested, usually with language barriers, or who disappear after leaving extensive requests and leaving said resident with no means of communication; (11) family members with restraining orders against them who have to be monitored to ensure they don't get into the home; (12) heavy-care residents with tube-feeds, IVs, fractures, bedsores—often admitted from hospitals—oxygen therapy etc.

None of the above are covered completely, if at all, under the current CMI formula or the one now being implemented. Care for palliative, psychiatric and high-needs residents is done at the expense of the rest.

There is excessive documentation, the latest being that the registered staff review and sign all the PSWs' documentation, in addition to our own charting and medication documentation.

There are increased falls from the no-restraint policies, with time spent sending residents to hospital for assessment.

There is time spent documenting unusual occurrences—aggression resident to resident, resident to staff, visitor/family aggression to staff and residents.

Cohort nursing: Time is spent in setting up all the isolation and then trying to keep wandering isolation residents in rooms, and extra time spent managing and reassigning aides' assignments to do cohort nursing, often with no extra staff—especially true for the evening and night shift.

There is time spent with family members with very sick and dying residents; also mentally ill family members.

There is time spent assisting PSWs when there's not enough help, keeping in mind that we can help them with their work but they can't help us.

Each admission takes four hours of paperwork to complete: care plans, assessments, drug orders, setting up the tick sheets, consulting with families, setting up referrals where needed.

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Documentation to comply with CMI/MDS: The conservative estimate is that it will take four to five hours to switch from CMI to MDS for each resident. Half of our registered staff have still not had the training. The extra time needed is not funded.

Time spent trying to accommodate the latest directive from the MOH, the most controversial, being that residents could not have their medications with their meals, resulted in very angry comments from the residents who were aware and demanded them anyway, resulting in the doctors having to write orders to this effect—more useless paperwork. The chaos this caused, especially in the mornings—it was tried, with less than encouraging results.

Three point five hours of care legislated as the minimum level for each resident would at least accommodate some of the heavier-care residents and ensure something is left for the rest. As it stands now, the rest get very little.



Thank you for allowing me to share with you a day in our life in LTC.

**The Vice-Chair:** Thank you very much. We have just 30 seconds left, so my apology. Thank you very much for coming.

#### OTTAWA HEALTH COALITION

**The Vice-Chair:** We'll move to the next presentation, by the Ottawa Health Coalition. The Ottawa Health Coalition is here? Okay.

Welcome back to our committee. I guess you have presented several times to our committee. You can start whenever you're ready.

**Ms. Marlene Rivier:** I'd like to start by thanking the last two presenters for giving us a view of life on the front lines in long-term care.

I'm here representing the Ottawa Health Coalition, which is a collective of community members and organizations in the Ottawa area committed to maintaining and enhancing our publicly funded, publicly administered health care system. We also act to generate discussion in our community about matters in the public interest related to health care and healthy communities. We work together with our sister local health coalitions and with the Ontario Health Coalition and Canadian Health Coalition.

We are disappointed that Ottawa was not selected as a site for these hearings, which we feel has diminished the opportunity for members of our community to contribute. Also, the timing of the announcement of the hearings was problematic, and we would hope that the committee would consider an extension to the consultation process. We would also appreciate there being a process for consultation in the development of the regulations that are to be established.

I'm not going to read my submission to you but just try to highlight a few things and acknowledge the work of the Ontario Health Coalition and ACE in their presentations to this committee and to indicate that we concur with their conclusions.

We're all aware of the fact that we have an increasingly needy population in our long-term-care homes. Patients are more quickly discharged to long-term-care facilities from acute care hospitals with serious medical problems. We're also seeing increasing numbers of individuals with serious mental health problems residing in homes, in part due to the closures of provincial psychiatric hospitals. Also, because of the decreased availability of home care, more people with physical disabilities are being forced into long-term care. We're seeing more younger residents who are finding a lack of age-appropriate programming, and we feel this is an important issue to be addressed. The residents' bill of rights, along with those concerns, also recognizes the needs of religious and ethnic minorities.

I am assuming that you've seen the convergence of views around the need to reinstate a minimum care standard, which was eliminated by the Conservative

government in 1996. We are calling for a minimum care standard of 3.5 hours of personal care per resident per day, with the understanding that the government will be carrying out research necessary to define the care levels more precisely. We're asking that, in developing the tool, which I understand is under way, attention be paid to the needs of people with mental health problems who are living in our long-term-care facilities and often require a great deal of care which is not captured by the current tool, which means that they are not getting the care that they are needing. That can result in a revolving door back into acute care facilities and specialty mental health facilities to help these individuals to regain their stability.

The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers.

We need in our long-term-care facilities a healthy, stable and well-trained workforce. Infection control is a real concern in view of the reliance on casual and agency staff. Surely SARS has taught us that when we have a very mobile workforce of low-wage workers who have to construct employment from a variety of casual jobs in various institutions, we are unnecessarily exposing very vulnerable residents to the risk of infection. Also, it's important for the social milieu that we have this stable workforce in our homes. Adequate staffing is necessary to protect residents from assaults involving co-residents and to stem the rising tide of staff injuries due to violence in the workplace. Inadequate staffing also increases the reliance on chemical restraints.

The presence of a registered nurse on a 24-hour, seven-day-a-week basis: It needs to be a nurse who is not a nurse manager but one charged with the sole responsibility to attend to the health care needs of residents.

We are calling for greater protection for publicly administered long-term-care facilities. There is a great deal of research that has demonstrated that the care in non-profit and public long-term-care homes is superior. Profits are maximized when staffing is minimized. Reduced staffing levels also impact the rate of staff injuries, and the cost of increased workplace injuries is in part borne by the taxpayer through WSIB claims. Over the years, we've seen operators shifting costs from the accommodation envelope from which they draw profit to the nursing and personal support envelope. This is something we know has had an impact on care and available staffing. We ask the government to take some real measures to correct that. There's been word of some efforts in that regard, but they don't appear to have had much impact.

Ontario has a preponderance of for-profit beds, exceeding the rates in other provinces. We believe it's in the interests of the public good that this trend be immediately and significantly reversed.

Not-for-profit board members typically serve in a voluntary capacity for the public good, and we believe that they should not run the risk of individual fines.

We're also suggesting that fines for non-compliance should be pro-rated in accordance with the number of beds of the entire organization rather than a single unit and according to status as for-profit and not-for-profit.

Advocacy is very, very important when we're talking about vulnerable people. It's important that councils have a voice in appeals and be able to obtain the necessary information they have to speak to inspectors etc. in order to effectively represent the interests of residents. It's also important that the independence of these councils from facility operators be established and maintained. We need an arm's-length third party who can play a role in assisting people in these facilities. We would propose an eldercare ombudsperson who can receive and process complaints.

Regular unannounced inspections must continue, without exception. Strong and effective sanctions need to be applied where homes are consistently non-compliant with significant care standards. That would include the non-renewal of the licence to operate. These inspections must include the contracted-out services in order to preserve a level playing field.

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In the interests of transparency and informed choice, detailed information concerning the results of inspections and key indicators of quality service, including average staffing levels and historical data, should be made available on a public, user-friendly website.

I've made a few comments about definitions and I'll just say that we concur with the Ontario Health Coalition that it's essential that we define the term "neglect" and that we agree with the Advocacy Centre for the Elderly to adopt the definition of "abuse" that's used in one of the ministry's policy documents.

We also want to underscore the necessity of making direct references to the Health Care Consent Act in this legislation to make sure that people working in these facilities and operating these facilities understand their obligations to obtain informed consent to treatment.

We also feel that references need to be made to the Personal Health Information Protection Act for the same reasons in terms of people fully understanding their obligations, to underscore the right of access of individuals and substitute decision-makers to personal health information.

We feel that the whistle-blower protection is really a keystone that needs some enhancement. Whistle-blower protection must be improved and such measures as gag orders in employment contracts must be made unlawful. Financial barriers to whistle-blowing must be eliminated and the legislation must embody strong deterrents to employers who may be tempted to dismiss or suspend employees acting in the public good. Penalties to employers who violate these provisions must be substantial and clearly spelled out in the legislation and/or regulations. The proposed provincial ombudsperson must have jurisdiction to intervene in such instances.

In conclusion, this submission is by no means a comprehensive examination of Bill 140. You have many

submissions before you which more properly aspire to that standard. In our submission, we have attempted to identify those aspects of the bill which we regard to be of fundamental importance in regulating the facilities in which some of the most vulnerable members of our community reside. In doing so, we hope to have fulfilled our responsibility as a health care advocacy group representing the people of Ottawa to speak to issues in the public interest and for the public good. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can divide it equally. We'll start with the parliamentary assistant. You have one minute.

**Ms. Smith:** Thank you for your presentation. We have heard from the health coalition in Toronto. We appreciate hearing from the Ottawa group.

I just wanted to talk a little bit about the minimum standard question. We're presently at about 2.86 in the province. I just wondered what the health coalition saw as being included in the calculation of the minimum standard as far as hands-on care.

**Ms. Rivier:** I don't think I'm in a position, really, to speak to the technical aspects of that, but my understanding of that reported number, first of all, is that there have been some questions about how that number was arrived at and the reliability of the information that was relied upon in arriving at that number. Also, I think it falls below the number that has been recommended as the bare minimum in terms of the prevention of risk. So I'm not particularly impressed. I think that I will leave it to the experts to determine how best to determine what that level of care should be, but clearly, 3.5 is a minimum.

**The Vice-Chair:** Mr. Yakabuski.

**Mr. Yakabuski:** Thank you very much for your presentation today. I appreciate you coming here from Ottawa, as well.

We've heard other presentations with regard to the increasing level of care that is needed by the residents today. I recall nursing homes that opened in the 1970s. People drove up in their car, unloaded the suitcase and went in. Now we're talking about situations, as you've articulated here, of people with significant mental challenges. I think it's proper to gauge that that is only going to increase the challenges for our staff in these homes. Where are we going to get to if this government does not (a) amend this legislation and (b) at least keep their promise with regard to the amount of funding they've committed to, which was additional \$6,000 per resident? Where are we going to be, say, a few years down the road, this piece of legislation unamended and that money not there? What's the condition going to be in our homes under those circumstances?

**Ms. Rivier:** Clearly the conditions in homes will continue to deteriorate, as they have been deteriorating since the Harris government removed the minimum standard of care.

**The Vice-Chair:** Thank you very much. Ms. Martel.

**Ms. Martel:** Thank you for your presentation. The government says right now that we're providing about



2.85 hours of hands-on care, but we heard from two groups of workers this morning, and the situation in their own homes was that they are averaging a little over two hours. If it's legitimate, 2.85 hours is less than what was recommended in the Casa Verde inquest. That recommendation was 3.06 hours pending a government review of needs, and, once that review was done, to reassess at that time. So we are a far cry from even what was recommended in Casa Verde. I'm wondering what was used to arrive at what the government's using as a figure now.

Why do you think there has to be a minimum standard that's actually legislated in place and why should it be done through this bill?

**Ms. Rivier:** I think it's the only way we can guarantee a proper level of care. We know that level of care doesn't exist right now and that some of our most vulnerable who are least able to advocate on their behalf are suffering because of it. I think we would all agree that a society is judged by the treatment it provides to those who are most vulnerable among them. I think it reflects rather poorly on us as a society that we have allowed conditions in our long-term-care facilities to deteriorate in the way that they have.

**The Vice-Chair:** Thank you very much for your presentation.

### SAFE SENIOR SYSTEMS

**The Vice-Chair:** We'll move to the last presentation for the morning session, which will be by Safe Senior Systems. Welcome to the standing committee on social policy.

**Ms. Janet Parry:** Thank you. My name is Janet Parry and I am vaguely connected to the Ottawa Health Coalition. But I'm here now to present my innovation, my invention, which is Safe Senior Systems. I am most honoured that you have selected me to appear before you.

Mr. McGuinty and Mr. Smitherman have realized that the provision of new, innovative equipment will help nurses and patients. I hope that my presentation will stimulate you to think about the basic issues that are challenging in the care of our aged population.

As you will have seen from my brochure, Safe Senior Systems is entirely relevant to every stage of senior care in the future, worldwide. The introduction of this system to the living accommodation of the patient allows the preservation of the dignity of the patient and convenience for the caregiver in facilitating these most necessary activities. It enables the patient to stay where they want to be, and not become a burden on the health care system—taxpayers—and/or their families. It cuts down on workplace injury to caregivers and clients and saves them time and unpleasant, unnecessary work. They might even have time to feed the patients, to make sure they actually eat the food.

Failure to cope with incontinence has many repercussions, everything from the great distress of lesions to the vast amounts of extra work and laundry, all of which are expensive.

Yesterday, the magazine *Rehabilitation and Community Care* arrived with an excellent article from Dr. Keast working with the Canadian Association of Wound Care. I brought you copies at the back of what has been developed into a book over the years that I've been going to trade shows. With his energetic and, I reckon, costly program, he is quoted as saying that they can save up to \$1.2 million per year in a 100-bed hospital and cut pressure ulcers by 35%—to which I say "Only?"

I have searched with no success for an estimate on the annual cost of monster diapers for the same-size facility. I was tempted to write to him and say, "Why don't we use my equipment and just not get the lesions?" but I'm only joking. It is a very difficult problem. We are dealing with frail, old skin, patients who have some mobility issues and, of course, poor nutrition causing failing health and strength.

Dr. Keast lists immobility, friction and searing—as attendants strain and injure their backs pulling and heaving patients—and wet, even soiled conditions as the primary contributing factors to the medical conditions he is seeking to address. At last, somebody is really doing some work on it.

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Further, in a previous issue of *Rehab and Community Care Medicine*, the publisher of that same journal—not the editor, the publisher—bemoans the new rules on diaper changes, the reduced frequency of which will of course be disastrous. It'll just make everything very much worse.

I should perhaps briefly describe what we are proposing. Safe Senior Systems, as you can see in my brochure, has four components which can be acquired individually and the other parts added according to the needs of the patient.

The first is a comfortable armchair with headrests and a reclinable back. Inside the chair there is a macerator toilet with pump. This is connected to two one-inch pipes which protrude at the back, one for water and one for waste, ready for easy attachment to any part of the plumbing system. It can possibly be put next to the bed at night to avoid those night trips and falls and hospitalization, which is one of the major troubles. The macerator is a well-established technology, most often seen in boats. The manufacturer confirms that it can be installed in any location in the house, which no doubt explains the tremendous success already being experienced in Europe.

The second is a strong support table, which attaches and can lock onto the chair. The table is sturdy enough for the client to pull themselves up and lean on while the chair seat swings up to reveal the toilet. If in rare cases assistance is required, it is only to facilitate a forward movement—"Up you come, love"; that's all it is. Compare that with sideways transfers, lifting and the risks associated with moving the patient onto and off commodes, and the long journey and waiting for the patient every time, not to mention the distress associated when the patient must also wait for the ever-scarcer assistance after they've completed all this. So this is a double whammy.

Third is the newly designed shower shell—that's the latest thing—which you can see on my website. It can be inserted under the patient, permitting washing to be achieved with a hand shower. The waste water is disposed of down the toilet with a flush.

These three units form the basic care package for home or institution. A fourth component is available to assist clients to remain in their homes longer, which is a major step forward.

One of the big dividing lines in geriatric care is when doctors and families determine that the patient can no longer live alone. The daughter knows she has to be working full time. Often the decision is based on the resources available for care, not necessarily on the extent of the illness or the competencies of the patients themselves.

The fourth item comes into use at this time: The rollaway can be added, possibly locked on, to the other two. I used to be very timid about saying "locks," but all the therapists said yes. It can accommodate everything that a patient could possibly need during the day alone: a four-litre fridge for snacks, a microwave, space for selected hobbies and entertainments to be accessible, a phone with pre-set numbers, remotes, converters etc. Depending on the situation, a respiration monitor or even a video monitor can be attached so that the daughter can see what's going on there. With these options, a worried daughter can, with confidence, say, "See you at 6, Mum. Have a good day." She can be assured there will be no "I just popped downstairs to put the kettle on" explanation for a broken hip or a burned-down house.

The patient can be seated comfortably for long periods, including, in recline, for naps. Being able to stand independently and safely provides much-needed exercise. Right from the start of the illness they've been doing this, so they never lose their legs, unlike those chairs that throw them into the air.

Another component which is being asked for by nurses is a foot-raiser.

Another dividing line is the transition from residence to long-term care. The reason is often incontinence. Once achieved, this decision is irreversible, even if it wasn't necessary or was due to infection or something.

The installation of even a few of the Safe Senior Systems chairs would be useful in all settings used temporarily for borderline patients, because nurses complain that there is no intermediate step between these two grades. Installation could be done in both residential and hospital situations.

I hope you will take time to visit the [safeseniorsystems.ca](http://safeseniorsystems.ca) website, where you will see the endorsements that have been received from nurses' unions and the Canadian occupational therapy association. Head nurses who were consulted during development said, "I can't think why this hasn't been invented before."

An accountant from the health service in BC, where they have extremely high statistics on seniors, could see at once the positive effect installation of Safe Senior Systems would have on reducing the pressure on his

service and the related financial implications. Whether installed privately by patients in their own homes or required by medical authorities, it would result in massive savings as well as satisfaction to people.

At present, with the aid of the National Research Council, or NRC, we are seeking to identify a manufacturer with vision to engage with us in the production of Safe Senior Systems, with the objective of having working pilot installations in place in several facilities in Montreal and Ottawa for inspection during the UN innovation show, Expo Ageing, which is to take place in Montreal in 2008.

I believe that there is a manufacturer who has had to change a diaper on his mother or empty his beloved wife's commode who will see the potential of this system and will engage in what is sure to be, given the demographic reality we're in, a very lucrative venture. We must remember that we are preparing this for ourselves and our families. I may say it's for you. I've got a safe senior system. Respectfully presented.

**The Vice-Chair:** Thank you very much for your presentation. We have about three minutes left. We can start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. Certainly it is something that those people looking forward to the future can expect to have at their convenience. Thank you so much.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you for your presentation. Can I ask what prompted your interest or your involvement in these technologies?

**Ms. Parry:** I had wonderful grandmothers, and I've been a therapist with geriatric interest all my life. I can remember being at a technology show for aging about eight years ago and thinking that it would be nice to have an armchair in the bathroom, and then thinking, "No, that's wrong." It's taken me this long to get here—and money.

**Ms. Martel:** How long were you providing occupational therapy? Were you doing that in long-term-care homes?

**Ms. Parry:** Yes, in geriatrics of all sorts. I did a lot of locums in Montreal—relief work—so that I would go and see all the various geriatric teams in almost all the hospitals. I also had I think four actual jobs, some in the UK and one here.

**The Vice-Chair:** The parliamentary assistant.

**Ms. Smith:** Thank you for coming. In our consultations early on in the process we heard a lot about aging in place and the real need for our seniors to stay in their homes as long as possible, because that's where they do best. And we've certainly gone a long way in trying to invest in home care and other resources in communities to allow our seniors to do that. Seeing the development of one more resource is always helpful, so I want to thank you for your presentation today and for providing us with this information.

**The Vice-Chair:** Thank you very much.



I believe the morning session is over. I want to tell the audience that the room will be locked, so I guess nobody is allowed to be here. Take your personal possessions with you. For the staff, you can leave yours here because I think you'll be back.

That's it. We are now recessed until 1 o'clock sharp.

*The committee recessed from 1158 to 1302.*

#### ROYAL CANADIAN LEGION, ONTARIO COMMAND

**The Vice-Chair:** Good afternoon, ladies and gentlemen. Welcome back to the standing committee on social policy for the afternoon session.

We're starting right now with the Royal Canadian Legion, Ontario command. I believe you know the procedure, sir. You have 15 minutes. You can use the 15 minutes for presentation, or you can divide it between presentation and questions. Please, before you start, state your name and your colleagues' names for Hansard.

**Mr. Jim Margerum:** My name is Jim Margerum, veteran services chairman, Ontario command. My colleagues are George O'Dair, our first vice-president, and Erl Kish, our immediate past president of Ontario command.

**The Vice-Chair:** Welcome.

**Mr. Margerum:** Ontario command of the Royal Canadian Legion thanks you for the opportunity to submit our comments and position on your proposed Long-Term Care Homes Act, 2006, Bill 140.

Ontario command has some 160,000 members and 424 branches across Ontario; in addition, our ladies' auxiliary has some 40,000 members and 132 auxiliaries. We have an enviable record of advocacy and service to veterans, seniors, youth and communities since 1926. We contribute millions of dollars and our volunteers contribute countless hours of their time to the above activities. We are one of the largest advocacy groups in Ontario, and we are very proud of our track record.

We will first address the failure of this bill and the Minister of Health to provide for an ombudsman to oversee long-term-care homes and investigate complaints of care. Our second part will be related to the proposal covered in Bill 140 by way of general comments and questions regarding the new legislation, its implementation of new requirements, time frames to comply with new provisions, and how the government ever expects the nursing homes to fund the heavy load it will place on their annual budgets.

Several comments and observations: We recognize the bill will bring all nursing homes under a single act and address seniors' problems and anomalies in the existing three acts currently covering nursing homes in Ontario. Finally, all will be singing from the same sheet and we will clearly define legislation and provisions applicable to all nursing homes, eliminating the differences and loopholes in the current three acts. This is long overdue and will result in improved standards, accountability, safety and security of quality of care provided to

residents in nursing homes in Ontario. While in principle we welcome Bill 140, we have serious concerns if it is enacted as presented. It will definitely impact the hands-on care to residents and the ability to find volunteers for boards of directors, and it will wreak havoc on nursing home budgets in their attempt to comply with new regulations, without taking into account the funding shortages they currently face.

Ontario command is very upset and disappointed that Bill 140 does not include an ombudsman to protect seniors residing in nursing homes, who are our most vulnerable citizens.

In early December 2003, when the Minister of Health, Mr. George Smitherman, was interviewed about the horrendous treatment some residents received, he introduced a number of measures to address the deplorable and unacceptable conditions uncovered by the Toronto Star series. One was more advocacy for residents in the form of a long-term-care ombudsman. At meetings with Ontario command representatives, we believe he made the same statement.

An Ontario government advisory committee, the Ontario Seniors' Secretariat's advisory committee on long-term care, which has 13 seniors' organizations and represents over one million seniors, unanimously recommended the implementation of an independent ombudsman for long-term care in a letter sent to the Minister of Health, the minister for seniors and the Premier of Ontario. Further, in their annual reports to the OSS committee, all 13 seniors' organizations supported the position as stated in the letter to the Minister of Health. Surely, when all members of his advisory committee on long-term care support this position to provide more advocacy for long-term-care residents in the form of an ombudsman, he should implement it within the provisions of Bill 140.

The Bill 140 proposal to create an Office of the Long-Term Care Homes Resident and Family Adviser instead of an ombudsman is no better than the current provisions he has as Minister of Health to appoint an investigator or investigating committee. It has not worked in the past, and the adviser proposal has no powers or authorities that are effective.

The most effective and simplest way to provide advocacy for long-term-care residents, spouses and/or family within Bill 140 is to provide the necessary clauses to expand the current mandate of the Ontario Ombudsman, Mr. André Marin, to include long-term-care homes and investigate complaints of care.

We are unable to comprehend the minister's reversal in his position and failure to provide for our most vulnerable citizens in Ontario, our seniors residing in long-term-care homes. Where is the transparency that the government speaks of in dealing with long-term-care residents' complaints? We have to wonder why he is afraid of an independent ombudsman reviewing and investigating long-term-care residents' complaints. This provides the advocacy role that is missing and is not addressed in a satisfactory manner in the proposed Bill

140. Surely our seniors deserve the advocacy role an ombudsman would provide to residents.

Our position is very clear, and Bill 140 must include provisions for expanding the current mandate of the Ontario Ombudsman to include long-term-care homes and investigating complaints of care.

Our general comments: We have concerns and questions about some provisions as outlined in the proposed Bill 140, and they are as follows. We realize we are not hands-on, day-to-day operators or professionals in long-term care, so we've left that to other presenters on what they face in trying to comply with the new bill and new legislation.

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We are concerned about the funding problems that nursing homes will face if required to comply with the legislation. How can their current annual budget handle the large funding required to implement the necessary measures to comply? There is no question that hands-on care and staffing services will suffer if they are required to take money out of the current budget and there are no provisions for phasing in necessary measures from the Ministry of Health or other government sources. What provision is there in Bill 140 to prioritize or delay some provisions to enable a home to comply without a reduction in hands-on care, services and staffing simply because their current budget does not have sufficient funding? We believe they already face staffing shortages, maintaining the obligatory level of care and the safety and security of residents.

We believe that more funding must be provided to enable a home to comply with Bill 140 provisions.

We believe that homes must have provisions for phasing in measures on a priority basis and within their funding ability until the government provides the necessary funding to complete measures to meet compliance.

While there have to be enforcement measures, punitive action—fines—to address homes that disregard Bill 140 measures, you must not penalize all homes. You have to have a reasonable time frame for a home to meet compliance, and their efforts to meet compliance must be measured and taken into consideration before any penalty is imposed. We believe that the enforcement area of the legislation is to weed out bad homes and should not impact the majority of good homes that we feel do their best within their ability and funding.

We feel that training, best practices and other measures must be provided for and funded by the government. This improves the hands-on care and service provided by a home, and they should not be denied this training simply because they lack the funding.

In closing, we strongly believe that providing care and support of residents in long-term-care homes is, and must be, a congenial and supportive partnership between the nursing homes, the Ministry of Health's long-term-care division and advocacy groups and organizations such as the Legion, service clubs, church groups and any other advocacy group in Ontario. Together we can accomplish a working relationship which will improve hands-on care, safety and security and the feeling of residents

being wanted and treated in a caring and dignified manner. Long-term care can be improved if we work to a common goal of ensuring that residents receive the best care that Ontario can deliver.

We urge you to make provisions in Bill 140 to include the implementation of an ombudsman by expanding the mandate of the Ontario Ombudsman to include long-term-care homes and to investigate residents' complaints.

We thank you for the opportunity for the Ontario command of the Royal Canadian Legion to present our submission to this committee.

**The Vice-Chair:** Thank you very much for your presentation. We have about three minutes left, to be divided equally among the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation today, General and, thank you for the work that you do with veterans who are in long-term-care homes and also for the work you do generally with veterans in the community.

You released a press release on October 5, 2005. You said, "At a meeting in March 2005, the minister"—that is, the Minister of Health—"asked the Legion to be patient and wait for this legislation to be introduced. He indicated that his government would have a solution and create an ombudsman to oversee long-term-care homes and investigate complaints of care." Do any of you want to comment on what was said at that meeting and what your understanding is of what was promised?

**Mr. Erl Kish:** Yes. I was at that meeting. The question was asked of the minister if we would have an ombudsman. He guaranteed us that we would have a person in the form of an ombudsman. Perhaps the terminology would be different, but the job would be done. I do not see the adviser as being a person who can do the job of an ombudsman. An adviser is an individual who reports back to his boss, not to Parliament as a whole. An adviser is another person in the chain of command who has somebody to work for, not for us as the public. An ombudsman does. So I think that the mandate he promised us was not given, and it's not the first time to do with health care that we have not received what was promised.

**The Vice-Chair:** Parliamentary assistant?

**Mr. Margerum:** Excuse me. In one addition in the back of the attachment you will find an interview with the Minister of Health in the Toronto Star dated December 8, 2003, where he definitely refers to the creation of an ombudsman to handle complaints. So that's with your attachments.

**The Vice-Chair:** Thank you very much. Parliamentary assistant?

**Ms. Smith:** Thank you for being here and for all the work that you do. Certainly, we've had chats over the years about the work that you've been doing.

I've been wanting to ask you some questions about your request for an ombudsman and the role exactly that you wanted it to play. The Ombudsman currently, as he is mandated, can only investigate a situation once it has occurred. So after an incident has occurred, they can go in. He can also choose not to investigate; it's his



discretion what he investigates. And he certainly doesn't have a role of advocacy on behalf of anyone; he investigates and makes a report. When we first started our discussions around the ombudsman/advocate role, we talked a lot about the need for someone to assist in managing the system, to advocate on behalf of residents or family members when they feel that their concerns are not being addressed. So I wonder about your request now to expand the role of the existing Ombudsman, whether that is really going to meet the needs that we had originally discussed.

**Mr. Margerum:** I would point out one thing that's most important. Earlier this morning, one of the presenters pointed out the fact that the best place to solve a complaint or a concern is on the floor, on the spot, as early as possible. However, we can document many complaints that were never resolved, and the final closure to that was coffin-led closure. Coffin-led closure is when the person dies and the family wants to get on with their life and they drop the complaint. Our concern is that some of them are systemic problems existing in long-term care and they have to be addressed. The reason for an ombudsman is for that very reason: to ensure that these problems don't carry on. If it is not resolvable within the level of the facility or at the first level with the Ministry of Health, it then goes to the ombudsman if the ombudsman deems the problem to be in his bailiwick or in his jurisdiction.

**The Vice-Chair:** Thank you very much. Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation, Jim and colleagues. Again, I just want to add my compliments to the work undertaken by the Legion. I am a proud member myself, and I do appreciate the work you do on behalf of veterans and members.

I guess there's disappointment concerning the fact that the ombudsman position, as you had envisioned it, is not contained herein. But I see it as quite simple. You're recommending that we make an amendment and expand the current mandate of the Ontario Ombudsman. Is that right? Is that your recommendation?

**Mr. Margerum:** Yes.

**Mrs. Witmer:** That shouldn't be too difficult to do.

**Mr. Margerum:** No. We discussed this with the current Ombudsman and others, and it is very easy for him, with minimal legislation, to extend his mandate to include long-term-care complaints, etc. The cost would be minimal; no more, and probably no less, than it would be to establish this new advisory role.

**Mrs. Witmer:** All right. And it would be totally independent from government.

**Mr. Margerum:** Yes.

**The Vice-Chair:** Thank you very much for your presentation.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1521

**The Vice-Chair:** We will move to the next presentation, which will be by the Canadian Union of Public Employees, Local 1521.

Welcome, and please state your name before you start.

**Mr. Steve Sanderson:** I'm Steve Sanderson, and Brian Blakeley is with me. He's a researcher for CUPE.

I want to thank you very much for this opportunity to speak to all of you. I want to let you know that my history is social services. I've been a social service worker since 1973 across Canada. I have worked since 1984 with the Ottawa-Carleton Association for Persons with Developmental Disabilities. In those 23 years I've supervised transportation, support, employment, residential services and respite care. I have also been the president of the local there since 1987. In that 20-year period I have been elected to the social services committee for Ontario six times, for six two-year terms, and I'm presently the third vice-president of the Ontario division.

I wanted to let you know that this is sort of a strange day for me because I'm talking about long-term care and it is exactly one year ago today—January 22, 2006—that my mother, at 94 years of age, passed away. She was living in a nursing home. By the way, she got very good care. We spent a lot of time looking for that home. She had excellent care and excellent supports. I will tell you that that was a not-for-profit home.

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What I did want to do today, though—and I think all of you have seen the report that was submitted on behalf of the Ontario division; I'm not going to speak about that. That was my president, Sid Ryan, who presented that. I've given you some information here on the issue that's most pertinent to my concerns. The issue I want to talk about is long-term-care home access protocol for adults with developmental disabilities. You will note the date on it is July 2006. For many people, myself included—and I'm quite connected—this flew below the radar for quite a long time. It's just more recently that a number of us have become aware of it. What I do want to talk about more than anything else—and I think I'm just going to have to quote from the actual document. There are two parts to it. You know that there are three major centres left that are open in this province, and they are being closed by 2009. So the protocol is about moving people from those institutions into long-term care. The second part is about taking individuals who are receiving services from developmental service agencies in our communities and moving them into long-term care.

What we do know already is that there are over 1,600 individuals with developmental disabilities living in long-term-care homes. On the last page of the package I gave you, there is a piece called "Diagnostic Categories of Younger Persons with Disabilities in LTCH." They use two categories, not my nomenclature but theirs: "mental retardation" and "Down's syndrome." That represents 691 individuals presently who are deemed to be younger. So there's a significant number of people who are already there. This is before a protocol is put in place.

On page 2, I want to give you a couple of quotes from the document to tell you why we are so frightened and

disturbed by this document. It says, in paragraph 3, concerning the DS facilities that are closing, "The DS facilities initiative presents an opportunity for DS service providers to consider the transition of individuals with increasing health care needs that they are currently supporting residentially into an appropriate LTC ... setting. This will create DS community-based capacity to accommodate residents moving from the DS facilities."

So, no increase in the number of beds, but taking people out of their homes and putting them into long-term-care facilities to effectively move people from the institutional settings. There is no support there whatsoever for the long waiting list in the communities.

On page 5, point number 1 says, "The CCAC must determine, as the first step of the LTC home placement process, that all community-based resources to meet client needs have been exhausted."

I'm going to refer to a couple of the other documents that I've put into your package. The third document, Quality Supports through Competitive Compensation—A Business Case, made by all of the different umbrella organizations in this province that offer services to people with developmental disabilities through all communities in this province, talks about the inability to meet staffing needs due to the chronic underfunding in the services. I will just read to you very quickly from the conclusion. It says, "The foundation of the developmental services sector is in danger of crumbling" because not enough money is being put into it. "However, the sustainability of this sector is at risk if community agencies cannot attract and retain qualified employees." We're having great difficulty getting people to work as a result of the lack of funding for those services.

The other piece I will refer you to, which you may have heard about already, is called Beyond Numbers. It's about the implications of financial restraints and changing needs of developmental services. That was for the Metro Agencies Representatives' Council, and that's in the Toronto area. The most telling statement is in their summary: "A squeeze is on: The sector has reached capacity, the service system is overloaded, and there are serious shortages in services. The capacity of the sector to manage current and future risk is of concern as service pressures continue to challenge the seriously depleted and stretched service system. The organizations do not have the resiliency they need to meet the service challenges ahead."

On the question of exhausting the system, it will be very clear that people will be moved very quickly into long-term care because the developmental service system is completely underfunded. This is coming not from me, but from the umbrella agencies that represent 95% of all the services that are offered in this province.

What I want to do now is just give you a couple of the other major concerns that we're fielding with regard to this document. For example, on page 7, it talks about individuals, but where there are a number of individuals applying for long-term-care home placement, there will be a method of dealing with that too. So now we're

talking about multiple placements of individuals from the institutions, whom Madam Meilleur talked about bringing into the community and into long-term-care facilities.

On the same page, item number 9, it says that where the needs cannot be met, the developmental service agencies in those areas will be forced to put their workers in there—so an intermingling of workers. But bear in mind that the agencies themselves do not have the financial capacity right now to deal with the needs that they have to take care of in their own agencies.

A final point that I want to make is on page 9, point 22. This is the scariest part for me. It says, "In situations where a number of individuals from one facility have been referred to a specified LTC home setting and there is a desire to maintain relationships, the LTC home may consider the development of a specialized area within the home to provide service to individuals with similar needs." So we have people in an institution, we move them to another institution, and then we put them into a smaller pod. How is that integration into our communities? I find this very, very troubling.

I know that the time is short, but I do want to mention a couple of other documents that I've put into the package. One of them is called Doublespeak: The Ontario Government's Betrayal of People with Developmental Disabilities by Dr. Patricia Spindel. For those who don't know her, Dr. Spindel is an expert in both developmental services and in long-term care. Her major thesis in this document is about the twisting and manipulation of the terminology used in the developmental services movement—"inclusion" and "equality," in effect—to re-institutionalize individuals with developmental disabilities into long-term care. She also has a very good piece on the history, moving from the Ministry of Health to the Ministry of Community and Social Services and now the move backwards.

I referred to a reporter by the name of Trish Crawford, who did two major pieces. One is called "Lost in Transition," which is about what happens to individuals after the age of 21: mandated services, no mandated services, extremely long waiting lists. The other one she wrote, which is very significant, is called "Fragile Fighters." It's about closing institutions. Her point is not that she's against that but that there's a multi-faceted lack of services available for people as they move into the community.

In fact, this document that I'm talking about, the protocol, is a way for the government, which is stuck right now, to deal with 1,000 people moving out of institutions without services, a chronic underfunding of the associations for community living that can't meet the needs, and waiting lists in the thousands across the province for people who can't get supports.

What I say to you is that this protocol has to be shelved; you have to get rid of it. You have to not put people into long-term care who should be in the community. I know that the government is putting in money, but there needs to be a significant infusion into services for those people who have developmental disabilities to actually be in our communities.



**The Vice-Chair:** Thank you very much. We have about three minutes left. We'll start with the parliamentary assistant. You have one minute.

**Ms. Smith:** You talk about the protocol a great deal. I don't know how the protocol impacts on Bill 140, but I appreciate your perspective today.

I do point out that the protocol is very clear at the beginning that each resident is assessed, and only where a long-term-care home is the most suitable setting to meet their health care needs would they be admitted into a long-term-care home. In Bill 140, as you know, we set out a great deal of our own protocols on assessments of needs and determining who in fact can be placed in long-term care. So I would suggest to you that given the restrictions that are in Bill 140, only those who have the appropriate needs would find themselves in long-term care in the province.

1330

As well, in this protocol that you've outlined for us, it is outlined on a number of occasions that each individual will be assessed to determine their needs. Of course, there would be no admission into a long-term-care home without that person's consent, and that's part of the legislation. My understanding is that the Ministry of Community and Social Services and the Ministry of Health are continuing to review this protocol, so that there are ongoing reviews. Perhaps you can just give a quick perspective on how you see the admission requirements under Bill 140 working in conjunction with this protocol.

**Mr. Sanderson:** I think it's quite clear—and that's why I brought up the issue of exhausting any other alternatives—that the alternatives will not be there. So it then becomes one of the choices that people make. I'm not saying that there will not be an assessment—that is not my point; simply that that's the route, and it's pushing people into those circumstances, to the point where we have multiple requests potentially being made to one home. How that happens, I don't know. It should be going to developmental services.

The other issue—

**Ms. Smith:** If I could just follow up on that point: If you've been here for some of the other presentations, you've heard a great deal of input from people about the waiting lists for long-term care and about the demand for long-term care. Your conclusion that there are no alternatives but long-term care and therefore they'll all be going in that direction just seems a bit at odds with the reality of the population already moving toward long-term care and looking for placement. I don't see how you see long-term care as being the only solution.

**Mr. Sanderson:** No, I'm not suggesting—I'm saying that the protocol is proposing it as a major solution. In light of the fact that many of the services are not available, that will become one of the choices. By the way, it also states that developmental services will offer services in those long-term-care homes.

**The Vice-Chair:** Mr. Runciman.

**Mr. Robert W. Runciman (Leeds-Grenville):** I was a little perplexed by your suggestion about surplus beds

in the long-term-care system because I know, in the city we're in at the moment, one of the problems with the hospital sector here is the lack of availability of nursing home beds and the fact that they can't move people out of the active treatment beds at the hospitals. That's causing, I think, a significant problem. I'm not sure if that applies right across the province.

I gather what you're talking about here is the additional investment in community-based services rather than what you're classifying as reinstitutionalization by going out of these facilities like Rideau Regional into long-term care. I know that the folks in my own area who are in the long-term-care sector are not enthusiastic about, for example, having individuals from Rideau Regional, who have very significant, heavy needs, being placed in their care. They think these are very significant challenges that they're not prepared to cope with and would rather see a facility like Rideau Regional, where these people at least would have the opportunity to live out their lives prior to that kind of a significant change taking place.

I guess you don't see a place in the province for institutionalized care for any kind of individual. Is that what you're suggesting in your proposal as well?

**Mr. Sanderson:** What I'm stating is, the reality is that there was a 2012 date for closure; it has been speeded up. That's causing a tremendous amount of turmoil because the services are not there in the communities.

**Mr. Runciman:** I agree.

**Mr. Sanderson:** We're trying to shift services out. People are not against that, but we need to have the basis for that. We need to have the doctors, the nurses, the physiotherapists; we need to have the staff in the residences and the day programs; we need to have augmented transportation services, and they're not there. So that's a major concern for us.

The reason I put the two together is because we are talking about the ministries coming together to work together on issues. But if the services are not present, then people are going to be put at risk, and people in long-term-care homes are going to be put at risk also, I believe. The 3.5 hours will not meet the needs. So why the protocol is there begs that question. That's why I want to say that there are 1,600 individuals already in long-term care who have a developmental disability of one sort or another, and there are younger people there too. We feel that it's more appropriate that they live in the community.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for your presentation. The relevance of this to Bill 140 goes back to a presentation we heard last week from the MS society, which strongly suggested that there were people with multiple sclerosis who couldn't get supports in the community and were being inappropriately placed in long-term-care homes. That's exactly what's happening with this protocol, and we've encouraged the minister on at least two occasions to get rid of it. It is telling service providers to force their clients who are now in the community into long-term-

care homes to free up spaces for residents who are coming in from Huronia. So we see a displacement of people now in the community into long-term-care homes to make space for people coming from the DS facilities. The issue is, why aren't we providing the funding to allow the people in the community to age in place?

It's interesting that the protocol also says that additional funding will come from the developmental services sector to support placements in long-term-care homes in order to ensure the supports and services are there so that the safety and well-being of other residents are not affected. Clearly it's not an appropriate placement and clearly the money in the developmental services sector should stay and be increased and enhanced to keep people in the community. I think that's what the point is with respect to Bill 140. I certainly hope that the government is going to shelve the protocol because I think many in the community sector know exactly what's going to happen here; that is, more people being forced into inappropriate placements and putting other residents and staff in those long-term-care homes at risk.

**The Vice-Chair:** Thank you very much. The time is over. Thank you very much for your presentation.

I believe the next presentation, by the United Steelworkers, has been cancelled. Is anybody here from the United Steelworkers?

#### COUNCIL ON AGING OF OTTAWA

**The Vice-Chair:** We'll move to the next one, by the Council on Aging of Ottawa.

**Mr. Al Loney:** So I get half an hour, do I?

Thank you, Mr. Chair, members of the committee. Our brief is very short. It doesn't mean that we're measuring it as being unimportant. The fact of the matter is that there are a number of things in the bill and the major thrust of the bill which we do like, but we have some caveats, and that's really what I want to point out today and not go through the whole iteration of everything you've heard before. I've read the briefs from a number of the different groups, including the Ontario Health Coalition and the Advocacy Centre for the Elderly, and I think they make some very good comments, but I want to go into a couple of things.

Funding has been mentioned repeatedly here but I don't think anybody sitting here in the audience or around this table can possibly see that more funding is not needed for the long-term-care sector. It's backed up badly. I don't know about every corner of the province in terms of it, but certainly in Ottawa it's backed up badly, although a few years ago, when a big number of new long-term beds came on, we actually had a surplus for a little while. But that's sure changed.

I think too that education of staff is vital. We see more and more dementia patients, more and more people with cognitive disability, and I think there's some special training needed by staff to know how to properly deal with these folks. Maybe that runs right into my next point, which is the high degree of illness and injury of

staff working in these long-term-care homes. I think a lot of the heavy care is really quite important there. I was in hospital visiting my wife recently and another woman was wheeled into her room who weighed in the order of 450 pounds. I saw the nursing staff trying to cope with that person. The reality is—I'm no little guy myself, and I'm telling you, there's an awful lot of work needed and an awful lot of help, and you have to have enough people and you have to have them well trained.

The matter of accreditation: We feel pretty strongly about this. As you undoubtedly know, in the province of Quebec and some other provinces, accreditation is a requirement. It's mandatory. In the system in Ontario it's still an option. I would like to see that made mandatory.

The amount of nursing care that's required: I guess we could argue forever on that. But we do feel that a minimum of 3.5 hours of care should be in the legislation and should be funded. I think those two are very closely linked. If you don't have a number to which you're at least going as the minimum, it's hard to then argue that, "Hey, my funding isn't enough." There are various weightings that have been put in this. I remember back when the criterion for going into a nursing home was that you had to require a minimum of 2.5 hours of nursing care. That's quite a few years ago. My hair is now white. I recognize that.

On the matter of restraints, I'm told there is legislation, the Patient Restraints Minimization Act. Why is this not part and parcel of this act? Why does it not apply? Why is there some, frankly, rather wishy-washy comment about restraint? I think that chemical restraint is altogether too often used. That's perhaps partially explained—by some, anyway—as being a lack of staffing, but the fact of the matter is, I believe that chemical restraint to the degree it's currently used amounts to elder abuse in a lot of parts of this province.

#### 1340

It has been a long time since this subject has been visited in legislation, and it would be nice to think we can get it right, and maybe it would last for a while again. But I really do feel that you have to address the issue in a very hard-nosed way and say, "Unless we're prepared to put more money in"—and I keep hearing about this extra \$6,000 per patient. Frankly, I think that would go a long way to redressing some of these problems with staffing. In our group, because we deal specifically with the elderly, we are very much aware that there is more and more heavy care—and more and more people. We're living longer, folks. Frankly, you may be great at 70, but you may not be so great at 95. The fact of the matter is that at some point we're all going to pay a little visit, probably, to a long-term-care institution. Those patients require much more care than the average patient did, I would suggest to you, 20, 30 or 40 years ago. That's where we're at.

I thank you very much for the opportunity to address you today. If you have any questions, I'll be glad to try to answer them.

**The Vice-Chair:** Thank you very much for your presentation. I guess we have a lot of time for ques-



tions—over six minutes, two minutes for each side. We'll start with Mr. Runciman.

**Mr. Runciman:** Thanks very much for coming in from Ottawa, I gather. I wonder about your own consultation in appearing before the committee. Is this simply members of the council, or do you talk to the operators and staff of long-term-care facilities to get some feedback from them?

**Mr. Loney:** Our organization is multi-faceted. We have a large number of various committees and task groups; one is called the house issues committee. Several of the providers sit on that committee, so these issues are addressed, and indeed the brief was discussed with that committee as late as last Friday before coming down here. These points that I've made are very strongly felt by that table.

**Mr. Runciman:** I know that I've met, I think, with every long-term-care facility in my riding. There seems to be unanimity in terms of a whole range of concerns, and you've certainly touched on some of them: the whole issue of licensing and the impact that's having on their ability to fund improvements to their own properties, for example; the director's liability in the non-profits—these are volunteers; the concern they're having with respect to being able to attract people to serve in that capacity under this legislation and the implications attached to it.

I have to say too, when we talk about licensing, I think there's a real concern in a riding like mine, and it would impact many areas in eastern Ontario which would be classified as small-town rural. Many of these facilities are the major employers—Kemptville is an example. I think the payroll there is about \$200 million. The bulk of employees are female. They're very concerned about their ability to meet these standards which are being applied without the necessary funding to meet them in many respects, inspectors coming in, and the possibility of beds being moved out of a region. That's the way they're interpreting this legislation: We could be losing not only the jobs and the economic impact, but also those beds for residents in a catchment region. I'm just wondering if you're hearing that kind of feedback from the folks you've talked to as well.

**Mr. Loney:** Yes, but the overriding comment that I would make is that it's very patient-centred. All of the concerns we have for the workers—and the owners of these establishments in some cases—are all secondary to the patient. I think we have to realize that the patient who's in there is the number one concern we all should have, and we should make sure that the funding and the regulations are such as to give the best care possible.

I don't believe that you can regulate every turn and every thing that happens, but you can regulate some basics. I think it should be done; I think it's well overdue. We need to make sure that when mother, grandmother, aunt or whoever goes into a long-term-care home, we don't have to go in three times a day to check on it to make sure they're all right.

We do a lot of work with elder abuse. More and more of the cases we're hearing there and with the special unit

with the Ottawa police are delving into cases in long-term-care institutions. The fact of the matter is, there is great concern in the community in terms of where we're going with all of this. You'd be hard-pressed to find anybody in a person-on-the-street interview process who would say, "No, you're spending too much money on long-term care and nursing homes." I think the answer would be the opposite: You're not spending enough.

**The Vice-Chair:** Thank you very much. Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. You said that you can regulate some basics, and I agree with you. One of those very basic things you can regulate, in my opinion, is the amount of hands-on care that a resident in a home will receive every day. There was a standard when we were in government. It was cancelled by the Conservatives. The Liberals, in the last election, promised to reinstate a standard. There is no standard for hands-on care that appears in this bill. The standard that should be in place is not the one that was in place 10 years ago, when it was cancelled by the Conservatives. It has to be, as you say, 3.5 hours.

Another area where staffing standards have been recommended and where the government has failed to respond is around the area of those nursing staff who deal particularly with people who are aggressive, who have behavioural issues. In a coroner's inquest that was carried out after the death of two residents by another resident at Casa Verde, one of the recommendations of the coroner's jury was that you have staffing standards in place for nurses who are dealing with people who have violent and aggressive behaviours. That is not in the legislation as well.

So when you talk about some basics, I think those are pretty clear, fundamental basics, and I hope the government is going to change its mind and put some staffing standards in place so that every home has to operate to some level. Certainly, more care can be provided, but at least there's going to be a bottom line of care for every resident in every home.

**Mr. Loney:** You don't think these guys are listening to me today?

**Ms. Martel:** Well, we'll see. Clause-by-clause is a week and a half from now; we'll see.

**The Vice-Chair:** Thank you very much. Parliamentary assistant?

**Ms. Smith:** In fact, we are listening, and a lot of the concerns that you've raised today are addressed in the legislation, so I want to be able to take this opportunity to point out some of them to you.

**Mr. Loney:** You'd better point them out.

**Ms. Smith:** You were asking about further consultation on the regulations. We have in fact said, last week in committee, that we will be consulting on regulations.

**Mr. Loney:** That's good.

**Ms. Smith:** You talked about the need for investment, and I agree there's an ongoing need for investment. As we describe it, long-term care is definitely a work in progress. We have invested \$740 million in the last few years—an increase in its budget of 34%. We've seen an

increase in staff of 4,800 in the last two and a half years, and that includes about 1,100 new nurses. You talked about some specific areas where you wanted to see improvement, including education and training for staff. I would point you to subsection 74(6), where we actually mandate that the homes provide training on abuse recognition and prevention, caring for persons with dementia, behaviour management, the minimizing of restraints, palliative care and other areas that can be included in the regulations. So it's right there in the legislation, your concern about dealing with dementia care and behaviour management.

You spoke a little bit about the safety of staff, and certainly that is of utmost concern to our government. We've invested about \$42 million in new equipment in the last couple of years, including lifts, which I think has improved the quality of life of some of our staff—although I recognize that it is a heavy workplace; there's no doubt about it.

You wanted to see the inclusion of the Patient Restraints Minimization Act. I would just point out to you that through sections 27 to 34 of the legislation, our restraint minimization regime is actually more comprehensive than the Patient Restraints Minimization Act. It includes PASDs, personal assistant support devices; it also includes some restrictions around transfer to secure units. The Patient Restraints Minimization Act is really focused on hospital use and hospital care, and in long-term care we thought that we needed a more fulsome restraint provision, and that's why it's in the legislation. So I'd just refer you to take a look at that.

Also, with respect to chemical restraints, subsection 34(6), I believe, is where you'll want to look, where we say that you cannot use a chemical as a restraint. Only a doctor can prescribe that, and if a doctor does prescribe it, there are some limitations and some reviews that have to happen in a home in order to limit the use of that.

I think that addresses some of your concerns, and I hope you'll have an opportunity to take a look and see what's in the legislation.

**Mr. Loney:** I would suggest that I've already looked at those sections, and I don't feel the wording is adequate, frankly.

**The Vice-Chair:** Thank you very much, sir, for your presentation. I think we're over time here.

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#### FRONTENAC-KINGSTON COUNCIL ON AGING

**The Vice-Chair:** Next will be the Frontenac-Kingston Council on Aging. Welcome. Before you start, please state your name and those of your friends who have come with you.

**Ms. Christine McMillan:** My name is Christine McMillan. I'm listed as the only spokesperson because I applied for a time to present to you. I'm accompanied today by Brian Brophy, who is the president of the council, and John Osborne, who is our

executive director. I also serve as the chair of the issues and concerns committee as well as secretary to the board.

**Mr. Brian Brophy:** The Frontenac-Kingston Council on Aging, founded in 1991, is a registered charity managed by a volunteer board of directors, the majority of whom are seniors. We are a member of the Councils on Aging Network of Ontario, all of whom share a deep concern about issues that demean the quality of life of seniors in our province. Our mission is to educate the general public and provide grassroots information and advice to decision-makers at all levels of government.

From our perspective, Bill 140 is the beginning of a good idea, similar to Herman, the cartoon character who looks at a square wheel he has shaped out of stone and states, "I think I'm on the verge of a good idea." Since the purpose of this consultation is to provide advice, we will not dwell on what is right with the bill but rather on amendments that we hope you will include.

**Mr. John Osborne:** Shortage of long-term-care beds: Right from Brockville through to Belleville last week, you noticed in the Kingston Whig-Standard headlines of how our hospital has come to a halt in being able to move people through. Desperate measures are being looked at, which brings us right to the forefront today. The shortage of long-term-care beds is a crisis in our community. Currently, 400 seniors are on a waiting list for a bed in long-term care. The Kingston General Hospital has 66 seniors in alternative-level-of-care beds in the hospital, which has created a crisis even for the use of surgery. They can't move people into these beds. The crisis may even worsen over the next 15 years, when it is estimated that the Ontario population aged 65 or older will soar to 2.7 million as the baby boom generation reaches its peak. That's an increase of 1.4 million over the 1996 census.

The hospital restructuring committee believed that the solution was in home care, but we have learned that keeping seniors in their home alone, with minimum care, creates its own problems of isolation and depression. Retirement residences provide an alternative for seniors who are able to afford the \$36,000 or more per year. For middle-income and low-income seniors there are very few options beyond this.

There is a great need for an affordable alternative to private retirement homes. We are pleased to report that the council on aging has received a small grant from the federal government's New Horizons for Seniors program to help put together a model for us in this community to start with.

We're recommending, in relation to short-term- and long-term-care beds, that the government take steps to relieve the pressure on long-term-care facilities and on alternative-level-of-care beds in hospitals by providing funding on a 24/7 basis for home care within various models of supportive housing to accommodate seniors and younger people with disabilities.

**Ms. McMillan:** You're going to hear a lot in our presentation, as I'm sure you've heard from everyone, about the need for additional funding. What I want to say right at the beginning is that the members of our council



don't accept that it's impossible to provide adequate funding for the care of our aging population, or that it will take years to resolve. As Depression kids, we saw what can be done.

In 1939, we had a minimal army, no naval vessels and no air force. By 1945, because there was political will, we had a well-equipped army, our naval fleet was the fourth largest in the world and we had an air force of which we were proud—and the debt was paid off by 1959. So we're saying to you, it is political will; it's not shortage of funds.

I'm going to quote something that John Gerretsen said on November 7, 2002. He's our honourable member and I think it's right that we quote it here. He said, "Do we really think, in terms of the way we take care of our seniors, that it's good enough to rank dead last when it comes to nursing services and personal care services we provide for our seniors in" long-term care? We couldn't agree more with that statement.

Both these documents are startling. What I'm referring to here is that there were two studies done. There was an auditor's report and the PricewaterhouseCoopers study. Both these documents were startling indictments on the care of our elderly citizens. Both identified that the level of care for residents in Ontario's long-term-care homes was and remains unacceptable. If you visit some of them, you'll see frail, elderly seniors secured into their wheelchairs, sleeping and slumped over. They line the halls of too many of the Ontario long-term-care homes due to overworked staff and underfunding of programs to stimulate residents.

The printed election brochure of this government stated that 2.5 hours of minimum care would be restored and that the previous minimum number of baths per week would be increased from two to three. It was expected by seniors that both these promises would now be embedded in legislation.

Other presenters have provided you with the statistics on standards of care in provinces throughout Canada. It is sufficient for us to say that we strongly support their contention. We are urging the government to amend Bill 140 to include a minimum standard of care of 3.5 hours per patient per day in long-term-care homes. We also urge that it be weighted by the assessed acuity of the resident's condition. In other words, there's 3.5 hours per patient, but if some patient needs four or five hours, they can get it because there's going to be some light care that won't need as long.

We urge the government to amend Bill 140 to include a minimum number of three baths per patient per week, as promised during the last election. And we urge that what they call "baths in a bag" not be considered baths. That is a short form for what's happening in order for residents to even get a sponge bath.

I guess the next thing that I wanted to really talk about was the nutrition in long-term-care homes. It's a constant complaint that we hear from families and from residents in long-term care. I'd like to quote for you something from Canada's Division of Aging and Seniors report. It

was put out in November 2001. It said, "Combined with physical activity, good nutritional status is a key element for seniors to avoid progression of chronic conditions. However, as health and functional capacities deteriorate, the prevalence of malnutrition increases dramatically, reaching 60% in nursing homes and hospital settings."

And then you heard the submission to the committee on finance and economic affairs this past December from the Ontario Association of Non-Profit Homes and Services for Seniors, in which they said, "Because of funding restraints, long-term-care homes are restricted in their ability to provide fresh fruits and vegetables that are an important part of any diet."

From our point of view, the issue of adequate food for residents in long-term-care homes is akin to the Dickens story of *Oliver Twist* in which Oliver in the workhouse is punished for asking, "Please, sir, may I have some more?" We went on a local shopping trip here. We used the Ministry of Health's nutritious food basket tool, and there is absolutely no way a resident in long-term care can receive adequate nutrition on \$5.46 per day. That must provide three meals a day, with a second choice for each meal, as well as snacks and nutritional supplements. If we deduct 10% for wholesale purchases, we were still looking at \$7 per day or \$49 a week. That's a long cry from the \$35 a week that nursing homes now get. In this regard, we're asking that the food allowance for residents of long-term-care facilities be increased to a minimum of \$7 per patient per day to meet the nutritional standards set out in the Canada Food Guide.

#### 1400

I want to go on to say that the lack of adequate food, in our opinion, would fall into the category of neglect under the province's own elder abuse guidelines. I think you've received a copy of our brochure, because we do elder abuse.

We're also concerned, and we heard in the discussion, that there's an allowance of \$12.64 per person per day for food preparation—this is really pretty sparse, because they have to grind, mince and purée versions of each meal. They have numerous special diets that they have to deal with. One of our fears is that, with a limited salary budget, there may be a tendency to provide only liquid canned supplements to those who are unable to chew or swallow. I draw your attention to the recent study by the Baycrest Centre for Geriatric Care, where they said that this is not adequate.

So we request that you review the food preparation allowance with the view of making it commensurate with the special dietary demands of the residents, including special preparation of food for those unable to chew or swallow.

Brian's going to lead us right into dental health for seniors.

**Mr. Brophy:** Dental care for seniors who reside in long-term-care homes, as well as those who live in the community, requires consideration by the Ministry of Health. While minimal dental care is provided to people on welfare, absolutely none is available to low-income

seniors. While minimal dental care is provided to people with disabilities under the age of 65, absolutely no assistance is available to them when they reach 65.

The recommendations made by the Ontario Dental Hygienists' Association to this committee is one which we ask you to seriously consider implementing. If good dental care was available for all seniors in long-term care, many would be able to chew and swallow their food; nutrition would be improved, resulting in fewer cases of infection; and the effects of gingivitis on the general health of the individuals would be reduced.

We recommend the Ministry of Health and Long-Term Care explore the cost of dental care for seniors who do not have dental insurance, both within long-term-care facilities and for those living independently in the community.

**Mr. Osborne:** Finally, of course, it all boils down to money: Where do we find in Ontario more money? But it does have to be found.

The senior population will be growing steadily all along. Right now, the overall funding for long-term care has not matched inflation, let alone the steady increases in seniors living their own lives for longer terms, and those being shifted from hospital beds, once considered—and funded—as chronic-care placements.

"Seniors themselves are making up the shortfall, paying almost twice as much in monthly basic accommodation fees as nursing home residents in British Columbia, Alberta, Saskatchewan, Manitoba and Quebec," as per the Ottawa Citizen's research by Paul McKay in the nursing home series he did.

Basically, we're recommending, first of all: Try to extend the tax base to cover the needed funds in the long-term-care system. But if not, then look at the current lottery revenues and see if we can draw more out and put more priority in that area for long-term care—if not, then the possibility of creating another lottery or other source of income that can be dedicated to long-term care and seniors' health.

We also have two other recommendations: 5 and 6. I'll go back to those—

**Ms. McMillan:** Maybe leave those, because we're out of time.

**The Vice-Chair:** Thank you very much for your presentation. I guess there's no time for questions.

**Mr. Osborne:** In conclusion, if I may wrap up: "A civilization is judged by the way it treats the most vulnerable of its citizens." That's Margaret Mead. Is the current state of long-term-care homes, the rising allegations of understaffing, underfunding and the lack of care and food for frail elderly men, women and younger disabled persons something by which you wish to be judged by history?

**The Vice-Chair:** Thank you again.

#### ALMONTE COUNTRY HAVEN

**The Vice-Chair:** We'll move to the next presentation, which will be by Almonte Country Haven. Welcome.

**Mr. Rick Gourlie:** Thank you. Ladies and gentlemen, distinguished guests and friends, my name is Rick Gourlie, and I am the administrator of Almonte Country Haven. It is an 82-bed C-class home in Almonte. I have worked in the capacity of a social worker, a front-line worker, a supervisor and an administrator with many populations, including autistic, mentally handicapped, victims of crime and senior citizens, working in Alberta, British Columbia and Ontario. So I thank you for this opportunity to speak about Bill 140 and how it will impact the residents of Almonte Country Haven.

I believe Bill 140 started out as a good piece of legislation but lost sight of what it was trying to achieve. The intention was to create a bill that would enhance the long-term-care experience, make life better for those living in it and anticipate the needs of those in the future. I am sad to say that somewhere our primary objectives have been lost.

I would like to address two major issues with Bill 140. The first is the limitation of licences, with no guarantees to the communities, the residents or the staff within the homes. The second is the increased documentation, which will translate into less time providing actual hands-on care.

Let me begin by saying that Almonte is located 20 minutes from Ottawa, yet, despite its proximity to the nation's capital, Almonte retains a very rural flavour. The residents who move into our home are people known to our staff. They're known to the residents in the home as well as to their families.

Many volunteers assist our home by offering both large, group programs and small, one-to-one individual programs. The inclusion of these community members in our home has been a key factor in our success. If Bill 140 is passed unchanged, Almonte Country Haven may have only seven more years of operation before our doors are forever closed—closed after nearly 30 years of compassionate service to the community; closed to the volunteers; closed to the residents and their families; closed also to the many staff who have worked for over 25 years in our home.

If you close our doors, you will punish the residents, their families and the staff as well as the entire community, because in our small town we are considered a major employer. You will punish all the people who have believed that they are building a place for their future. Imagine how an admission process is going to go: Families will soon learn not to select a C home for fear of possible closure in the future—so the need to relocate a loved one in a foreign home in a foreign community.

We need the committee's reassurance regarding the continuation of our home in Almonte. Please don't make the mistake and think that the community will forget the actions of closing a home within their community only to then open another home in a different community. Indeed, the community will become jaded. So please, listen carefully; act wisely.

To address my second point, I refer to the Residents' Bill of Rights. It's a cornerstone upon which the ministry



standards were founded. I believe the intention behind the creation of the Residents' Bill of Rights was to allow us to see issues through the eyes of the resident.

**1410**

I hope the ministry is better able to understand the implications of what it proposes by telling you of a resident's life from Almonte Country Haven. This is the story of a woman named Louella. Louella opened the Almonte Nursing Home, operated that nursing home and later was admitted into the same home that is now called the Almonte Country Haven.

Louella opened the Almonte Nursing Home in the late 1950s, and during the days when Louella operated the home she gained a reputation as a woman of great conviction and kindness. Louella once told me that the key to her success was that she genuinely cared about each and every person who was admitted, and she always had time to listen to their stories. Louella would often pass my office, call out and say, "Come out here, you. Talk to these friends of mine." Then she'd laugh because what she'd said was, "At the end of the day, it's not what you write in that book that will make a difference. It's what you do and how you touch their soul. That's what people want."

In 2001, Louella moved into the home that she had actually created. She lived in a four-bed room. Louella was not a rich woman. She had lived her life giving to others without concern for herself. She believed in creating a legacy, a living legacy. Every morning Louella would wheel down the hall in her wheelchair, greeting residents with the same morning greeting. She'd call out, "Make a good day of it, now. You'll have to work at it, but do your best to make a good day of it." Those are simple words, but in that regard I am here today to make a good day of it and work at making Bill 140 good legislation for everyone.

In our home, many of the staff joined our workforce straight out of school. They never had a desire to move to a big city; they wanted to build a life within their community without a commute, a life that would have purpose. They have been able to achieve this at Almonte Country Haven. They chose a profession that has allowed them to have hands-on impact on the quality of life for the residents. They did not choose this career to record every aspect of their care, to document everything from intake to output so that all of this could later be offered up as proof to the ministry that the care they are providing has actually been provided.

The ministry does not seem to understand that the need to provide the many layers of documentation actually takes time away from the individual who's giving the care. Louella had it right over 50 years ago.

Bill 140 is designed to create an intimate relationship with documentation. We are being forced to focus on the proof of care, not the provision of it. Here are just a few examples.

Subsection 6(6) requires that resident and family have the opportunity to participate fully in the plan's development and implementation. There is, however, no

guarantee that all of these people will be available to be interviewed or contacted. So the only way that a home can demonstrate its compliance is to set up a paper-based system that can be shown to the inspector who comes to document this involvement.

Subsection 15(2) sets out the requirement for measures to encourage the participation of volunteers from a list of organizations. Once again, the only way to demonstrate that this is happening is to document all of these measures and the communication with all of the listed organizations.

Subsection 18(3) requires communication of the zero-tolerance-of-abuse policy to everyone attending or visiting the home. Homes will have to print off and circulate the policies on a daily basis, and can only demonstrate compliance through the tracking of their distribution.

Sections 28 to 31 set out the requirements relating to restraints. Again, more documentation will be required to demonstrate that each element of these sections is being met. This is not because there is currently widespread use of restraints, but rather it's because Bill 140 establishes magnetic locks on exterior doors as a restraint. In our 82-bed care home, this perimeter barrier would be a restraint for 65% of our population. So that means 54 people will have to have hourly checks, with the corresponding documentation to demonstrate the check was completed. This potentially would translate into 24 hours in a day times 54 residents times 365 days, which would equal 473,040 entries in a single year. If it takes about 10, maybe 15 minutes to do your check and make your documentation, over a one-year period that time will translate into 118,260 hours, or the equivalent of 60 full-time workers.

*Interruption.*

**Mr. Gourlie:** Thank you very much. Clearly this was not the intention of Bill 140. The current hourly checks are not specifically intended for perimeter barriers.

Clause 76(1)(d) sets out that each home must provide any revisions to the information package to any person who has received the original package. This will require regular updates, as well as a system to track who has received the original information package and then subsequently who will receive all the revisions within the packages. Without documenting this, how can we demonstrate that this has happened? We'll have to document it to confirm compliance.

Subsection 76(2) sets out the content of information packages that will have to be created. Inspectors will have to verify in more than 600 homes that these packages do comply with the legislation. Similarly, any revised packages will require inspection for compliance. Clause 78(1)(b) sets out that regulated documents will have to be certified by a lawyer. Each home will have to set up a process and create the required paper trail to demonstrate complete compliance.

These are just a few examples that are in addition to our current documentation requirements. Clearly, Bill 140 is not about providing better care. It's about revising policies, setting up procedures and putting in new

protocols to meet compliance so that documentation will be in order for the inspectors. It says nothing about care.

The simple act of holding hands, offering support and human contact is lost with the adoption of Bill 140. My friend Louella would be shocked to learn that Bill 140 is placing documentation over human contact. Louella believed in creating a legacy, one that you can be proud of, a legacy that reflects both care and compassion.

I ask you, if you were scared, alone, confused and living in long-term care, what would you prefer—someone who would hold your hand and offer kindness and reassurance or documentation?

Don't limit our ability to offer care by restricting our licences and don't overburden us with more documentation. Please, help fix the problems with Bill 140 and join us in supporting the OLTCA's proposal and Elizabeth Witmer's private member's motion to enhance the legacy that was started so many years ago with a kind and caring woman by the name of Louella.

**The Vice-Chair:** Thank you very much for your presentation. There's no time for questions. Thank you very much.

1420

#### PROVIDENCE MANOR FAMILY COUNCIL

**The Vice-Chair:** The next presentation will be by the Providence Manor Family Council. Welcome. If you don't mind, can you state your name?

**Ms. Carol Robertson:** My name is Carol Robertson, and this is Linda Dowdle.

Thank you for this opportunity today. Actually, the previous speaker had me at Louella.

We're here today representing the family council at Providence Manor. I would like to start by telling you a few things about us. We also have a brochure which we have included in your package.

Providence Manor is a charitable home in Kingston with 243 beds. The family council at Providence was founded in October 2004. Currently, we have 16 active members and a staff liaison that meet monthly.

The council has developed its terms of reference. Council members sit on a variety of Providence committees, such as long-term care, laundry, the dining experience and diversity awareness. The council has also provided information and in-service to other families on such matters as power of attorney, a program on how to feed residents and a Parkinson's support group. We also initiated and submitted a petition to John Gerretsen, our MPP, requesting additional funding to increase the minutes of care for each resident.

We have implemented a life history project for residents so that staff and residents can better appreciate the rich life that each resident has had prior to coming to Providence Manor. The council is in the process of developing an action request form for families or residents to use to address unresolved issues.

We would like to speak to you today about four key areas in Bill 140:

(1) Provincial staffing standard: As families, our biggest concern is the quality of care that our loved ones receive. We believe that quality care is significantly dependent on the amount of time that staff can spend with a resident. The present model allows for residents to receive between two and 2.5 hours of care per day. This is a minimum amount of time which does not recognize the complex care that many residents require to move, dress, bathe and eat. In addition, without enough time for personal contact and interactions, the dignity of the residents is lost.

We are requesting that Bill 140 establish a provincial staffing standard, and that this standard provide for a minimum of 3.5 hours per day of nursing and personal care for each resident. We are also requesting that the bill recognize that specialty units for residents who are aggressive or significantly cognitively impaired need a different staffing standard and a staff with a particular set of skills in order to provide the level of supervision and interaction required. We would like to see a separate provincial staffing standard for these units as well.

(2) Level-of-care funding: Every resident in long-term care has a care plan based on the needs and, to some extent, the preferences of the resident. At present, the funding model allows long-term-care homes to meet only the minimum care standard of this plan. Other areas that add to the quality of life for residents and maintain their dignity are not recognized. An example of this is toileting. Ideally, a resident should be able to use the bathroom for as long as possible. However, time constraints often mean that a resident who requires help to get to the bathroom and assistance in the bathroom is forced into briefs earlier than necessary. Another example is that a resident who requires help walking ends up in a wheelchair earlier because of lack of staff time to walk with him or her. Meal time is another example. Many residents require feeding. A lack of adequate staff members at meal times means that residents have to wait for food, get rushed through their meals and eat cold food.

We see a gap between what the bill provides for resident care and what the current level of funding actually provides. To close this gap, we are requesting that Bill 140 direct the ministry to assess residents in a fashion that raises the current minimum standard of care and fund this higher standard. We feel strongly that new money must be directed to hands-on resident care rather than creating elaborate reporting structures.

(3) Transfer of licences: All long-term-care homes in the province receive money for nursing and personal care, food, programs and support. The money in these envelopes must be spent as outlined by the ministry and cannot be transferred to other areas. Flexibility in spending comes from the accommodations envelope. Providence Manor takes money from the accommodations envelope to increase the nursing envelope by 18%. Likewise, Providence Manor takes money from the accommodations envelope to increase the amount designated for food. This makes Providence Manor a home that centres its decisions on the residents.



In contrast, in for-profit homes, all profits must come from the accommodations envelope. Exceeding the nursing and food envelope would reduce profits. To make money from the accommodations envelopes means a compromise of the quality of life for residents in comparison to life in a public non-profit home. We firmly believe that it is not in the best interests of the residents to allow the transfer of licences or beds from non-profit to a for-profit long-term-care home.

We request, therefore, that Bill 140 strongly support maintaining public and non-profit delivery of care in long-term-care homes. We also request that the provision which allows non-profit long-term-care licences and beds to be transferred to for-profit homes be removed from the legislation altogether.

(4) Family councils: We believe that all long-term-care homes should be required to have a family council. We believe that family councils' input should have a mandatory role in the inspection process. We believe that Bill 140 should provide for some provincial funding to support family councils.

In conclusion, one thing we all know for sure is that the aging process happens. If we were having brain surgery, we wouldn't want a doctor or a surgeon practising minimal standards. We wouldn't want our children in daycare centres that just meet the minimum standards. Why, then, are we satisfied with the minimum standards for a group in our society that is so vulnerable? Bill 140 is our chance to get this right not only for residents in long-term care now, but it also puts us on the right path for ourselves and our loved ones in the future. Please support our request for improved standards of care, additional funding in our long-term-care homes, and for continued support of public and non-profit long-term care.

Thank you for this opportunity.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We'll start with Ms. Martel—two minutes.

**Ms. Martel:** Thank you for your presentation today and the work that you do on the family council. I wanted to ask you—because I think you mentioned an assistant, and I'm not sure if that's somebody who is from the home as well, a staff person who gives support to the council? Am I correct in that?

**Ms. Robertson:** Oh, it's a liaison.

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**Ms. Martel:** And is this a staff person?

**Ms. Robertson:** Yes.

**Ms. Martel:** The bill specifically states, "In carrying out his or her duties, a family council assistant shall take instructions from and report to the family council." There have been concerns raised by other family councils that that might mean a staff person, and so they don't want to see that at all. Do you have a sense of that? You have someone already. Is it working, not working? What's your sense?

**Ms. Robertson:** Our experience has been that that person only comes for a portion of the meeting, and it's only during that portion that she either gives us feedback

that we have presented for her homework and on which she is responding back to us, or questions at that meeting that we might have for her, and then she leaves the meeting. In our experience, that system has worked very well.

**Ms. Martel:** Okay. So what we need is the ability to have some discretion about coming and going, and that being set up.

**Ms. Robertson:** Right.

**Ms. Martel:** Just in terms of what you see in your own home, and I want to go back to staffing standards, it's really clear that a significant amount of money is being topped up to actually have staff in place, and even that's not doing the trick, I would gather. What do you see as some of the shortfalls around the staffing that need to be addressed?

**Ms. Robertson:** In my own experience, and my mother is at Providence Manor, an example would be that it takes me an hour and a half to feed my mother when I'm feeding her. Staff have to do it a lot more quickly, because of the time allotment. So if staff take the time I take, it would already be four and a half hours a day just in feeding, not to mention all the other needs that she has.

I think another example that I can give from my own specific case is regarding safety. Last year, while my mother was being cared for in bed by two staff, Mom fell from bed, and I think it was because they were hurrying; they were rushing through the personal care in bed. Just over Christmastime, Mom suffered a broken arm. Again—

**The Vice-Chair:** Thank you. Parliamentary assistant?

**Ms. Smith:** Thank you for your presentation and for the work you are doing at Providence. I had a chance to look at your brochure, and note that a lot of the things that you do and the purposes that you see for the family council are reflected in the legislation in section 58, where we outline what we'd like to see family councils doing.

I just wondered: Your family council was created in 2004. Did you have some assistance from the family council project, which received some provincial funding in order to help some of the homes?

**Ms. Robertson:** No.

**Ms. Smith:** You weren't part of that?

**Ms. Robertson:** No. What we've received so far is a \$30 donation.

**Ms. Smith:** Okay. But did you have the support—they had an outreach worker in the eastern region. I met with some of them in Ottawa, and I thought they were working their way through Kingston. Did you have any support from that worker, that outreach person?

**Ms. Robertson:** We attended a family council conference.

**Ms. Smith:** Right. The one in Ottawa?

**Ms. Robertson:** No, the one in Kingston.

**Ms. Smith:** Oh, in Kingston. Great. Well, I appreciate the work that you're doing.

In your outline of some of the things you do, you “identify and address concerns and issues” and try to come up with constructive resolution of issues. How is that accomplished through your family council? What are some of the things that you do to accomplish dispute resolution?

**Ms. Robertson:** Right now, as I said in the presentation, we’re working on a resolution form. Of course, the problem is not quite as detailed as Bill 140, but it’s trying to get a form that suits the needs of all the residents and that can be implemented in the home for the use of families in order to resolve issues.

**Ms. Smith:** Great. You also talked a little bit with Ms. Martel about the assistant that you have. That’s a staff person?

**Ms. Robertson:** She’s a liaison.

**Ms. Smith:** A liaison; sorry. And that’s a staff person?

**The Vice-Chair:** Thank you.

**Ms. Smith:** Are you cutting me off?

Sorry. I’ll ask you after.

**The Vice-Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation. That’s a great brochure that you’ve put together. I appreciate the work that you do on behalf of families. I think family councils are serving a very useful purpose in the province of Ontario.

You are requesting here some funding to support family councils. How would you suggest that this funding be provided? Should it be based per resident? And why should you get money? For what purpose would it be used?

**Ms. Robertson:** That’s a really good question. As I said earlier, we just received, and have spent, the \$30 in two years. It was a donation.

A lot of our costs involve money for paper in these brochures and also for the printing of the minutes. We also have just initiated a welcoming card so that when the resident is new to the home and has been there for two weeks or so the family will get a card welcoming the family to the home. So we really haven’t got many expenses yet and, as I say, we’ve just spent our \$30 donation over two years.

**The Vice-Chair:** Thank you very much for your presentation.

#### ONTARIO HEALTH COALITION, KINGSTON BRANCH

**The Vice-Chair:** The next presentation will be by the Ontario Health Coalition, Kingston branch.

**Ms. Fern Giddings Pilato:** Good afternoon. I’m Fern Pilato, not Ross Sutherland. Ross is out of town. He is the chair of the Kingston branch of the Ontario Health Coalition. I’m going to be reading this because I have a propensity to start on something and then start thinking about something else, and I need to stay in line.

The agreement between Ross and me was that I would focus upon the need for the people of Ontario and their government to include 3.5 daily care hours as a minimum

standard of care for each long-term-care resident in Bill 140, 2006. He asked me on Wednesday. I got the legislation—the draft bill—read it, and on Thursday learned that I didn’t know all my resources. I heard through an e-mail, serendipitously, that there would be something else that I could use. Then I heard it on the radio station; that, of course, is the rocking chair group that was out front. So, for this presentation, I am going to use the identifier of being a Canadian senior citizen at large.

I want to thank you for coming to Kingston, particularly Shelley Martel, Monique Smith and Elizabeth Witmer, as well as all the other members here at this table and in the audience. I want to also underscore my assumption that everyone present is an advocate for long-term-care residents. That means seniors and younger disabled folk. Without a doubt, I am not satisfied by having plus or minus 6% of my cohorts and many younger folk residing in what I broadly consider to be almost warehousing with conveyor-belt characteristics.

With 10 minutes, I can only address the 3.5-hour issue by means of a macro approach versus a micro approach since Bill 140 is comprehensive, with 11 extensive parts.

My supportive points for the inclusion of 3.5 arise from the preamble; part I—fundamental principle; part II—rights, care, and services; part V—operation; as well as part VI—funding.

Preamble: “The people of Ontario and their government ... affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term-care homes.” Please note that in 2006 and today quality of life includes health promotion. The history of the people of Ontario and their government is also something worthwhile to note. In 1986, the Ottawa Charter for Health Promotion and Achieving Health for All were adopted. That was 10 years ago, before 1996, when Ontarians and their government withdrew the 2.25 hours of personal care as a minimum standard to replace it by zero, nought. One year earlier, in 1995, the Ontario Auditor General reported that inaction on issues such as staffing mix and appropriate levels of funding meant there was no basis to assess whether further funding was appropriate to meet the assessed needs of the residents. An overview of this phenomenon certainly stimulates red-flagging of possible resident abuse.

The government at that time ran under the banner of Mike Harris’s new revolution that was devolving towards a return to a colonial society where quality of life for all had not always been respected versus evolving towards a quality of life for all of society.

**1440**

Furthermore, the 2002 Ontario Auditor General’s report underscored the same situation as the 1995 report, while the 2004 report found only a few areas where there was at least a minimum charge. Today there remain zero hours of personal care as a minimum standard. I did get the Auditor General’s report that was just released about six weeks ago, but I didn’t get time to read it. An overall



view of the pattern of no change certainly stimulates red flagging of possible resident neglect.

Recommendation: the MDS—minimum data set—with the RAI—resident assessment instrument—yielding appropriate care plans that can be individually implemented PDQ—pretty darn quick. This system is excellent for assessing resident care needs for delivery of appropriate services, compliance monitoring and funding decisions. Canada has been one of the 16 countries doing research on this system for well over 15 years. Ontario facilities have been involved.

My recommendation is that you get 3.5 hours to be included in Bill 140.

Part I, Fundamental principle and interpretation: a long-term care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort.”

Please note that dignity underscores the need for delivery of care services to adhere to standard-of-care practices by all disciplines. Nursing services have been timed and studied well over time. Adequate case mix staffing is well documented and readily available.

Recommendation: that “they may” should be “they shall,” as “may” does not indicate commitment, and also that 3.5 hours be included in Bill 140.

#### Part II,

Residents: rights, care and services: Please note that that the Ontario Medical Association has been clear on the need to amend the intent and verbiage in specific areas, and I concur. Therefore I will not address this issue of what they have said in my presentation.

#### Residents’ Bill of Rights:

“(3)13 Every resident has the right not to be neglected by the licensee or staff....

“11. Every resident has the right to....

“ii. give or refuse consent to any treatment or care for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.”

Please note that this is a very grey area and incidents do surface that require significant staff time for resolution. For example, 1.5-inch-long mycotic toenails. A resident refused podiatry for months and the family complained to challenge staff to get the toenails cut.

“iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act.”

Please note that this presents many challenges when working with other agencies and requires significant tech staff time for a mutually acceptable and amicable resolution. For example, a resident fell, was sent to ER and returned with no hard-copy X-ray report. He only received a telephone call stating that nothing was fractured. The next day, the resident was in pain and could not walk. Pressure had to be applied to get an X-ray report faxed to discover that the resident had a hairline-fractured pelvis. You can’t do anything about it except to apply medication until it heals. This required

significant staff time for amicable and acceptable resolution.

“12. Every resident has the right to receive restorative care services to promote and maximize independence to the greatest extent possible.”

Please note that this is supported by Canada’s 1986 charter for health promotion, Ontario’s current Action Plan for Healthy Eating and Active Living, and Kingston Gets Active. Implementing this requires much time for staff education and implementation hours. Methods are well documented.

“23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.”

The Ontario Ministry of Health Promotion website supports this. What I’m getting at is that we need those 3.5 hours to be included in that bill.

Look at the plan of care, section 6: “The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, dietary, recreational, social, restorative, religious and spiritual care.” The MDS system does this. A full-time MDS coordinator is essential. All charge nurses must know how to complete the hard copies for quarterlies, annuals and change in conditions. The MDS coordinator will log into the ministry’s database to input the information after reviewing the hard copies completed by the charge nurses.

I’m going to “Dietary.” You can read that.

Assisting residents to eat takes time. They should not be rushed. A meal should be a social event, and that takes all of us at least 20 minutes. You should have 20 minutes to eat, for health promotion.

The ministry truly needs to address processed-food and canned-good usage. Most are highly seasoned with salt or use salt as a preservative, while most residents have a cardiovascular diagnosis that is best cared for with a low-salt diet.

Example: A physician underscored concern and this need of a family friend, a resident. The physician spoke to the RN, licensee and dietitian about the resident’s need to have a low-salt diet. That weekend, the physician arrived at mealtime, assessed the food, assisted the resident to pack and left the long-term-care facility with the resident to be cared for in a private home.

#### Recommendations:

(1) that the Ministry of Health Promotion include the portfolio for seniors and the seniors secretariat versus the Ministry of Tourism—I had to get that in somewhere;

(2) implement in-house cooking to control salt content;

(3) that 3.5 be included in Bill 140.

Family councils: “May have” should be “shall have.”

The “if any” that is attached to “family council” throughout Bill 140 needs to be deleted. A family council should be integral to a well-functioning long-term-care facility.

Operation of Homes, Training: Oh dear, how many seconds do I have?

**The Vice-Chair:** You have two minutes.

**Ms. Giddings Pilato:** Okay. Listen, there's really a problem going now in the health care field for the personal care sector. A registered nurse now requires a university bachelor's degree. We have people with associate degrees. There's a definite difference that I can see in the intuitive knowledge care: intuitive practice. That's what you get as an expert after five years of being in a profession. You can see the difference. There's a real challenge there.

RPNs continue to go to associate diploma programs. But there are three cohorts of them. There's one group that could never give parental-method injections.

Another one got robotic treatment: Feed them like turkeys to put them out in the market. You teach them what to do but they don't have the knowledge behind it. Now you finally have—we now have; excuse me—a system where they will get some knowledge and practice.

But it's very, very difficult for the registered nurse because she or he has to look at this and assign work judiciously, knowing that those three things, those three differences, are there. It's very difficult in the unionized situation where seniority counts. Really? And knowledge, skills: The Italians have a good way of saying something about that.

PSWs are the nursing care extenders of registered nurses and work through the registered nurse's licence. Ultimately, the RN is responsible for the PSWs' performance, and this is another challenge in a unionized long-term-care setting.

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In conclusion, the nursing/personal care milieu is challenged by this phenomenon. There are five levels of training on occasion just for nursing staff.

Orientation: the residents' bill of rights. I recommend—and I do this with everything that I have. I worked with the Texas attorney general's office as a volunteer ombudsman. The state was divided into 24 regions, and we each took the one with the most complaints. I recommend that the LHINs, the local health integration networks, for each region in Ontario have one full-time elder abuse coordinator who would assist the local communities as well as the long-term-care staff. Meanwhile, approach Laura French of the Prince Edward county CCAC, Christine McMillan of the Frontenac-Kingston Council on Aging, and Sue Carr of the Kingston police.

**The Vice-Chair:** Thank you very much for your presentation.

ST. LAWRENCE LODGE

MAPLE VIEW LODGE

**The Vice-Chair:** We'll move to the next presentation, by St. Lawrence Lodge and Maple View Lodge. Wel-

come. Before you start, please state your name and the names of your colleagues. You can start any time.

**Mr. Mike Kalivas:** I will do that right now. Good afternoon, ladies and gentlemen. My name is Mike Kalivas. I am chair of the committee of management of St. Lawrence Lodge, located just outside the city of Brockville. I'm also a councillor for the city of Brockville. With me today is a United Counties of Leeds & Grenville councillor, Mayor Ron Holman, who is the chair of the committee of management of Maple View Lodge, located in Athens, Ontario. Joining Mayor Holman and I are Tom Harrington, administrator of St. Lawrence Lodge, and Denise Owsianicki, administrator of Maple View Lodge. Together, our homes provide care and services for 284 residents.

First, let me state that we believe that the quality of life and well-being of our residents is our number one priority, and we believe that the same can be said for the province and the government of Ontario.

Our homes are proud of the care and services that we provide for our residents. Furthermore, our municipal partners believe in providing for the vulnerable in our society, particularly frail persons requiring long-term care. Our municipal partners have a long history of going the extra mile for our residents.

This tremendous commitment is evidenced by ongoing substantial financial contributions and annual top-up to provincial operating funding levels through municipal contributions to the operating budget and, most recently, the major redevelopment and rebuilding of these two homes at significant capital cost to our municipal partners. Consequently, we believe that our leadership and commitment to providing residents with quality care services is consistent with the spirit expressed in Bill 140, in that "a long-term-care home is the home of its residents ... it is a place where they may live with dignity and in security, safety and comfort."

However, we are quite concerned about several aspects of the proposed legislation. We believe that, without significant amendment, Bill 140 imposes a formula for disappointment rather than success for our long-term-care homes. Furthermore, we are very concerned that if Bill 140 is proclaimed in its present form, without a substantial new financial commitment by the province, our municipal partners' ability to sustain their legacy of caring will be severely jeopardized.

We further contend that the government of this province needs to clearly reflect on the feedback received through this consultation process about the serious negative implications of Bill 140, in its present form, on homes in Ontario. It is incumbent on the government to ensure that our comments and concerns and those of others be given serious consideration before this bill is passed. Significant changes to the proposed legislation are needed if it is to have the intended positive effect on the daily lives and well-being of our residents.

The first point I wish to comment on is the immediate and direct impact on resident care as a result of Bill 140,



since this bill places great emphasis on the enforcement of standards.

As you are no doubt aware, long-term-care homes are already seriously challenged financially by current funding levels. Our homes are challenged daily to deploy scarce human and financial resources to meet the ever-increasing care needs and expectations of the people we serve. Staff, in particular, find it more demanding and difficult to meet significant daily workloads. They report that work duties are rushed and there is not enough time to do the little things that are so meaningful for our residents. The need for substantially more new operating dollars is well-documented and I don't believe that we need to expand on the increasing acuity and demands related to direct resident care experienced by long-term-care homes across Ontario.

To meet this very evident need in our homes, our municipal partners invest an additional \$1.7 million over and above Ministry of Health and Long-Term Care operating dollars. We believe that this necessary investment provides stable levels of direct-care staffing for our residents.

The concern we have here is that Bill 140 proposes a significant increase in accountability and compliance with standards. Specifically, we are concerned about the level of detail that will have to be produced to prove beyond a reasonable doubt that our homes are in compliance with all aspects of the legislation and regulations. This undoubtedly will require extensive time for staff surveillance, monitoring and supervision, and subsequent documentation, reporting and follow-up.

The new expectations, as outlined in Bill 140, will surely deflect more staff time and energy away from the bedside. Resident care will diminish, unless there is a dedicated investment of new funding in direct support of Bill 140. We believe this required investment has to be clearly distinct from the investment required to close the current funding deficit gap between resident care requirements and operating funding provided by the province.

It should be noted that our resident councils and family councils wholeheartedly support this principle. Furthermore, these councils believe that closing the gap between the level of care required and the level of care funded should be a major government funding priority in the upcoming budget.

Extensive requirements to monitor and prevent resident abuse is another potential area of concern related to the new act. Our homes take their duty to ensure zero tolerance very seriously. However, section 17 of the bill imposes a duty on homes to "protect residents from abuse by anyone." This mandatory obligation has inherent and significant obligations for our homes. For example, imposing this obligation requires the home to somehow manage and monitor not only all interactions between residents and staff, but also other residents, their family members, friends, personal caregivers and other external service providers—a big task indeed, with over 284 residents under our care.

Use of restraints will also pose new challenges under Bill 140. Our homes promote a least-restraint philosophy;

however, St. Lawrence Lodge is particularly concerned about the inclusion of a secure unit as a restraint.

Our concerns stem from the following situations. First, from our review of the bill, there are no defined timelines identified to guide the provision of rights advice for individuals admitted or transferred to a secure unit. Therefore, we see real implications and challenges for our local health care system. For example, an admission to the secure unit coming from the local hospital could be delayed due to an extended rights advice consultation process. Second, it is also uncertain what the current capacity in our region is for skilled people with the necessary qualifications to provide rights advice. Finally, extended delays in the secure unit admission and transfer process could conceivably cause St. Lawrence Lodge to be financially disadvantaged by loss of resident days and, subsequently, ministry revenues.

This new legislation will impede or deny residents the special care they need in a secure unit and will again have a profound impact, not only on the home itself but also the home's health care system partners.

The next theme I want to speak to is governance. Bill 140 imposes a heightened level of liability for municipal councillors, appointed by their municipalities to our committee of management, through its harsh approach to duty of care. The bill states that every person on the committee of management who fails to take all reasonable care to ensure that the operation of our home complies with all requirements under this act is guilty of an offence. The penalties under Bill 140 far exceed similar accountability sanctions against members of hospital boards and this approach seems unreasonably excessive and harsh for work of a similar nature to hospital governance. If Bill 140 proceeds, our municipalities may find it difficult to get councillors who are willing and prepared to assume personal liability and risk by accepting an appointment to our committee of management.

#### 1500

As I stated earlier, the level of care provided to residents living in long-term-care homes across Ontario is not keeping pace with the level of acuity. Our municipal partners are exhausting their ability to augment current provincial government operating funding. Bill 140 will no doubt place a tremendous administrative burden on our homes, and this burden should not be borne by our long-term-care residents and our municipal taxpayers. The funding provision in section 88 must commit the government to properly fund long-term-care homes for the work that they do day in and day out. The current language states that the government "may" provide funding. Our residents, their families, and our municipal partners are unanimous and adamant that this wording should be changed to "shall." The provincial government can no longer rely on municipalities to fund the provincial government's shortfalls.

As part of our submission, I would like at this time to also express our homes' support and endorsement of the presentations to the standing committee on social policy submitted by the Association of Municipalities of Ontario

and the Ontario Association of Non-Profit Homes and Services for Seniors.

In conclusion, St. Lawrence Lodge and Maple View Lodge are proud of their tradition and heritage of caring for frail and vulnerable persons requiring long-term care. Our municipal partners strongly support that caring tradition.

Our homes want to continue to work with our partners to deliver the best care possible to those persons entrusted into our care. However, as it stands, this new legislation will impose substantial hardship on our homes. We fear we will fail our residents because our homes will not receive the provincial operating funding necessary to meet these new requirements. Our municipal partners have answered the call to help meet the need. Now it's the province's turn to truly be a leader in long-term care. Our residents who built this province deserve the best.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We're going to divide them equally between the three parties. We'll start with the parliamentary assistant, one minute.

**Ms. Smith:** Thank you for your presentation. Just around the secure unit and some of the issues that you had about the secure unit as a restraint, the Health Care Consent Act does apply and we also provide for the placement coordinator to seek rights advice for the potential resident prior to admission. As well, the section that requires rights advice says that it will be sought promptly. So I think some of your concerns around delay for rights advice and the admission into a secure unit will be for naught given that we can seek it. You probably have a waiting list; most homes do. So if someone is on a waiting list and in need of a secure unit, you will have the ability to get that rights advice while they're waiting. As well, if there is a situation where someone is in a crisis situation and needs immediate admission, the Health Care Consent Act would apply. That person could be admitted and then we would seek rights advice as a follow-up to their admission in order to deal with the crisis situation. So just to deal with that particular concern, I think it has been addressed in the legislation.

**The Vice-Chair:** Mr. Runciman?

**Mr. Runciman:** I want to thank you for being here, knowing both facilities and the outstanding facilities they are and the staff and the volunteers who play a role, including the municipal councillors.

I'm curious, Mike, about the secure unit. Have you done any analysis? I know we had a presenter earlier who talked about this section of the act and did, I think, a marvellous job of dissecting the bureaucratic madness of it in terms of the paperwork required. Have you done any analysis of what it might mean to your institutions in terms of cost and time associated with meeting these requirements?

**Mr. Kalivas:** I'll let Tom Harrington address that.

**Mr. Tom Harrington:** In terms of the actual timing, just to give you a sense of the scope, we have approximately 35 to 40 transactions, if you will, in terms of transfers into the special care unit, as well as transfers in

and out within the facility itself over the course of the year. We're very fortunate that we have assistance from the Royal Ottawa Hospital site, which is actually adjacent to our facility, and we have access to those resources.

The time and energy spent on that certainly takes a lot of staff time. It involves the family congruence with those decisions, and the involvement of the substitute decision-maker in certain instances as well. I can't give you a full scope on it, but it certainly is a time-intensive activity.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you for your participation today. Over and above that, thank you for the municipal share that goes into the operation of these two homes, which is quite significant to provide what is probably a minimal level of care. I mean, you want to provide more, but if that contribution wasn't there, imagine what it would really be.

**Mr. Kalivas:** What would happen.

**Ms. Martel:** Exactly. Let me ask a question about liability. What do you want to see the government do with respect to the sanctions that it proposes to apply to the committee of management if that committee fails to take reasonable steps to ensure that the home complies with all the requirements?

**Mr. Kalivas:** I don't understand why we need to move to a new level. I'd put the question back to the government in saying, "What's wrong with what we're doing now?" Do we need to make a change? I don't necessarily see that. Obviously, for the reasons stated, if we're going to have a move to a new, heightened level, it's going to create complications—I see that—and it will be councillors who will refuse the opportunity to serve on that board. We can't control every person, every act that's happening in the home—and if that does happen, they're going to be charged for it? It doesn't make any sense to me.

As far as I'm concerned and as far as governance is concerned, I think those things are working well now. I don't know why we necessarily need to heighten that to a new level. That doesn't make any sense to me. If we're threatening the role of the committees of management across the province, where are we going with that? We need to reword that to ensure that we have the confidence so that we're willing to serve on these boards. I'm proud to serve on that board, and I don't want to walk away from that because someone else is telling me there's a liability factor. Come on; that doesn't make any sense.

**The Vice-Chair:** Thank you very much.

#### HELEN HENDERSON CARE CENTRE

**The Vice-Chair:** The next presentation will be by the Helen Henderson Care Centre.

Welcome to the standing committee on social policy. Can you please state your name and your friends' names?

**Ms. Susan Scriver:** I will. Good afternoon. I'm Susan Scriver, chairperson for the family council at Helen



Henderson Care Centre. With me are Larry Gibson, Angela Gibson and Lisa Gibson, administration there.

On behalf of my mother and others who reside at Helen Henderson, I thank you for this opportunity this afternoon. I wanted to meet with you today to try and put a face on the people you make decisions for. In doing so, I hope you will compassionately consider Bill 140 and those who will be impacted by your vote.

At this time in my life, I have one of the greatest responsibilities, next to motherhood, one could have: I am, not through choice, the mother to my mother. I do not like this role, but I do take it seriously, and in doing so, I do not feel that my mother or others are being treated fairly by this act. And although not politically knowledgeable in many areas, I do know first-hand about long-term care and its effects on people and the families who are under its umbrella.

My family's story started just over five years ago in a different city and a different home. Both my parents suddenly ended up in long-term care. But I won't go into every detail of this maze of events. Instead, I will briefly detail bits of our journey.

With the help of caring professionals, we were fortunate to get both our parents in the same facility, or so we thought. And like other families in this situation, we faced the confusion of our lives changing and our roles reversing.

Our first long-term-care experience was not a positive one. This long-term-care experience introduced us to administrative neglect, resident-caused abuse, and a system, lawyers and people who had no idea what impact they made on the lives of others. It was our family's nightmare.

My father has since passed away, and for the past two years my mother has resided here in Kingston. She is in a loving, caring environment at Helen Henderson Care Centre, and our family has finally found peace and trust within the long-term-care system because of the staff who work there. But now, with Bill 140, you have threatened my mother's and my family's peace of mind. You do so in the callous way you present the uncertainty of whether this home will continue to be in our community because Bill 140 places a 10-year deadline on this home's operating licence, yet nowhere does this bill answer the question of what happens after that. The way I read it, the government would be able to do whatever it decides, everything from maintaining the status quo to closing the home and moving the beds elsewhere.

This alone causes great worry for the staff who live and work in this community, as well as all families involved. What bank would provide our administrator, Larry Gibson, money for structural updates—or any money, for that matter—when, with this bill, you could shut him down within a 10-year period? Therefore, I ask you to please amend the licensing scheme that will be imposed on existing B- and C-classified homes.

1510

What I don't understand is that this bill is helping provide for residents who live in new homes and rebuilt

D homes. The government provides a 20-year contribution of \$75,000 per bed toward the construction of these homes. My mother and others pay the same as these residents, yet you don't feel they deserve the government's commitment to provide funding for their home? I ask you to please amend this bill to commit to a plan of action to invest in the upgrading of older B- and C-classified long-term-care homes.

Overall, Bill 140 is a resident-focused act, and I am relieved to see the provisions on the prevention of abuse. However, part I, section 1 of this act is entitled "the fundamental principle," and it states that "a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort." This fundamental principle inadvertently seeps out to us, the caregivers, as well. When first reading this, it gives us a little peace of mind, knowing this is a principle our loved ones in care deserve. We are pleased to know our government agrees and even guarantees it by making it law. Yet after reading the whole bill, I am forced to ask: Where is the dignity, security and comfort when one must worry about the possibility of being evicted because of this new licensing scheme?

Where, may I ask, is the dignity for our residents who smoke? This government should be embarrassed at the humiliation it caused our veterans who fought for a free country. They have been kicked to the curb to do something some of them have done for over 70 years. I question this government's decision to randomly rule that all smoking rooms need to be updated. What about families and administration making educated decisions on behalf of their residents? Why does this government feel the need to dictate?

But even more importantly, this bill does not address staffing hours of nursing and personal care for residents in everyday life. Bill 140 needs to be responsible by planning a factual funding system, or at least one that would recognize a minimum standard of care, like other provinces in Canada, of 3.5 hours of care per day per resident.

In order for this bill to be effective and responsible to its residents, it is imperative that adequate staff are in place to fulfill its well-intended purpose. As well, adequate staff are needed to cover the many additional hours this act creates in paperwork. Adequate staffing is needed for this act alone and to meet the increasingly complex care of its residents.

My mother requires a great deal of time with her care. She is wheelchair-bound and needs to be manually lifted by a hoist a minimum of three times a day. These procedures can take up to half an hour for each move, and because of past abuse by another resident in a different long-term-care home in a different city, she is terrified and co-operation isn't easy. A great deal of time and patience are needed when dealing with my mom due to her first introduction to long-term care, one where she was not protected from this severe abuse, causing her to live in fear for the rest of her life. In a very short time

after her admission, gone was the trusting woman we brought into care, gone was the woman who never raised her voice, gone was the woman who never had to fear someone approaching her—and not because of her illness, but because of neglect, abuse and understaffing. Yet fortunately today, the compassionate staff who provide her care somehow make the time to help her deal with this fear. They somehow find the time to reassure her.

The time these dedicated, special people need to spend with my mother is far more than 2.5 hours a day. I can't imagine the stress on the staff who lovingly care for so many residents with their own unique personalities and health problems. I worry this stress will in time wear them down and burn them out, and then my mom, along with others, will not continue to get the compassionate care they do now.

Funding is definitely needed for increased staff. When I feed my mom, it takes at least 45 minutes for one meal. I ask you to take note of your own elderly loved ones the next time you share a meal. How long does it take them to eat? Remember, they're healthy. Then think about the staff in long-term-care facilities who are expected to feed all the residents in their care three meals a day, plus tend to their other personal needs, on 2.5 hours of care a day.

Two baths a week is good for some residents, but in reality, an increase in staff is needed to provide them. For my mother, I had to make the choice of one bath because of the trauma this causes her. So now, when that second bath day comes along, she and others have time taken away from them in order that staff is available to provide the second bath.

Activities at Helen Henderson Care Centre are varied and many. It is an amazing program, with fantastic leadership and staff. This department goes way above and beyond the call of duty. However, to ensure people can enjoy these activities, staff from every department are helping transport residents to each activity, taking time away from their own duties to do so. Just the same, there are still many residents who for various reasons cannot attend and who remain in their rooms or in hallways. Loneliness is evident in long-term care. Perhaps if the issue of adequate staff was addressed by Bill 140, then loneliness could be addressed too. I ask you to please amend Bill 140 to address adequate staffing hours of nursing and personal care to include a minimum standard of care of at least 3.5 hours a day per resident.

Time is of the essence, they say, and time is all most residents have. They have lost the ability to fill time. Therefore, it becomes our responsibility to ensure that the essence of their time is filled with dignity, and dignity comes when someone can take the time to acknowledge and understand the other, time to make one feel not only a valued member of society, but a valued member of life. Dignity is not just caring for the body; it involves caring for the human spirit. I wonder if sometimes, getting caught up in the routine and all the hard work that goes into a people project, we can lose sight of the frailty of this spirit. Well-intended as we are, maybe we could do just a little better if we had a more hands-on approach or if we were able to put a face to those we will affect.

Bill 140 overall addresses many issues we as families want put into law. I want you to remember that this act affects real, everyday people like my mom, each with their own differences. They cannot all fit into the same category; therefore, compassion is needed as one of its main ingredients.

In closing, I ask that when considering Bill 140 you remember how your decisions will impact the lives of others. Thank you.

**The Vice-Chair:** Thank you very much. There's no time left for questions.

**Ms. Scrivener:** That's fine; thank you.

#### VINCENT DAGENAIS GIBSON LLP/SRL

**The Vice-Chair:** We'll move to our next presentation, which would be by Vincent Dagenais Gibson LLP/srl.

**Mr. Russell Gibson:** Good afternoon and thank you, Mr. Chairman. My name is Russ Gibson, but I'm no relation to the other Gibsons who were the previous presenters. I'm here with my colleague Jennifer Leddy, and we are from Vincent Dagenais Gibson in Ottawa, which is a law firm which has for over 100 years represented institutions, corporations and many diverse charitable and not-for-profit corporations and associations, including nursing homes and hospitals. We are not representing a particular client today. The perspective we bring comes from our work with various not-for-profit and charitable corporations in the health care sector, particularly religious organizations.

Bill 140 combines the provisions of three previous pieces of legislation and contains over 200 detailed sections. In our brief presentation we will address four topics: the residents' bill of rights, the mission statement, the duties of directors and officers, and the regulations. We have three amendments to propose respectfully to you.

We support the spirit of the bill to create long-term-care homes that are resident-centred and accountable, where people are respected and may live with dignity and in security and comfort. While the bill of rights is an eloquent expression of the rights of the individual, rights exist in community, and dignity is realized in relationship with others. The common good of the group must therefore be taken into account and the religious nature of homes owned or sponsored by a faith group respected and protected. Many people are drawn to faith-based homes precisely because of their religious character, and it is in this setting that they feel most at home. Long-term-care homes operated by religious organizations also have a history and tradition of excellent compassionate care, good stewardship, and respect for human life and dignity.

1520

Given that subsection 3(3) of the bill allows the resident to enforce the bill of rights against the licensee, and that subsection 3(4) allows for regulations setting out how the bill of rights shall be respected and promoted by the licensee, it is suggested that a new subsection be



added to protect the religious freedom of faith-based homes.

Our proposed amendment is that a subsection should be added to section 3 on the Residents' Bill of Rights. Some possible wording for your consideration is as follows. You will see that it is similar to the provisions in sections 26 and 28 of the Local Health System Integration Act.

"Nothing in the Residents' Bill of Rights shall unjustifiably, within the meaning of section 1 of the Canadian Charter of Rights and Freedoms, require a licensee that is a religious organization or sponsored by a religious organization to provide a service that is contrary to the religious teachings of the organization."

We have a related concern with respect to the provisions in section 4 which require mission statements to be consistent with the Residents' Bill of Rights. Religious communities and faith-based organizations are very familiar with mission statements and have usually spent years developing them. For religious congregations, they are often closely connected with the spirit of their founder and the teachings of their faith.

Given that the mission is integral to the integrity and identity of religious organizations, we propose for your consideration an amendment that might read as follows. The wording, again, is similar to the provisions in sections 26 and 28 of the Local Health System Integration Act.

"Nothing in this section shall unjustifiably, within the meaning of section 1 of the Canadian Charter of Rights and Freedoms, require a licensee that is a religious organization or sponsored by a religious organization to include any provision in the mission statement that is contrary to the religious teachings of the organization."

Thirdly, regarding the duties of directors and officers of a corporation in section 67, our comments are as follows. According to section 67 of the bill, every director and officer of a corporation that is a licensee must take all reasonable care to ensure that the corporation complies with all requirements under the act. Every person who fails to comply with this section is guilty of an offence. The penalties for failure to take reasonable care are set out under section 177. For a first offence, the penalty is a fine of up to \$25,000 or imprisonment for a term of up to 12 months or both. For a subsequent offence, the penalty is a fine of not more than \$50,000 or imprisonment for a term of not more than 12 months or both. Compensation or restitution may also be ordered paid to any person who has suffered a loss as a result of the offence.

By contrast, regulation 965 of the Public Hospitals Act requires the board of directors to monitor activities in the hospital for compliance with the act, the regulations and bylaws of the hospital and take such measures as the board considers necessary to ensure compliance with the provisions of the act, the regulations and the bylaws of the hospital.

The penalty for contravening any provision of the act or regulations is a fine of not less than \$50 and not more

than \$1,000. Clearly, the penalty provisions of the Public Hospitals Act are generally less onerous than those proposed in Bill 140 and do not include any jail time.

The duties under both the Public Hospitals Act and Bill 140 appear to be the same: to ensure compliance with the act. The focus, however, is on the collective board in the Public Hospitals Act and on the individual officer and director in Bill 140. Is this simply because most hospitals are incorporated or is it a deliberate move to impress on directors the seriousness of their responsibilities?

The question is whether the standard of care for fulfilling directors' duties is the same in the two pieces of legislation. Under the Public Hospitals Act the board has to monitor compliance and then take such measures that it considers necessary to ensure compliance. That suggests a subjective and less onerous standard. By contrast, Bill 140 requires the directors to take reasonable care, which suggests a more onerous, objective standard.

The statutory duty of care of directors of business corporations is an objective one, namely, to exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. This means that all directors, irrespective of their background or education, must meet the same standard.

Directors of not-for-profit organizations must meet the common law standard of care, which is more subjective in that the degree of skill required of a director is what may be reasonably expected from a person of similar knowledge and skill. Directors are required, according to the common law case of *Re: City Equitable Fire Insurance Co. Ltd.*, to "exercise such degree of skill and diligence as would amount to the reasonable care that an ordinary person might be expected to take in the circumstances on his or her own behalf, but he or she need not exhibit in the performance of his or her duties a greater degree of skill than may be expected from a person of his or her knowledge and experience." For example, an accountant would be held to a higher standard of care on financial matters than a teacher.

Some commentators are of the opinion that the distinction between objective and subjective standards is becoming blurred, given the courts' increasing reliance on business cases, the law reform movement in this area and the difficulty of attributing board decisions according to a variety of skill sets. However, it is confusing to have two apparently different standards of care within the not-for-profit health care sector, especially when some hospitals own and operate a long-term-care home and use the same board to govern the hospital and the home.

While recognizing the vulnerability of residents in long-term-care homes and applauding the intention of the bill to create and enforce safe environments, the proposed duties for directors with the possibility of jail for non-compliance will increase the difficulty of attracting volunteers to the boards of not-for-profit organizations. Directors' liability insurance may also be more costly, more difficult, or impossible to obtain.

We also agree with other presenters to this committee that noncompliance with standards and the incidents of

abuse and neglect are less likely to occur where there are enough staff to do the job and funding to improve the surroundings.

It is suggested that the proposed duties for directors and officers and penalties for noncompliance be amended to bring them more in line with what is required of directors and officers of public hospitals.

Regarding regulations to be made pursuant to the proposed act: Even though Bill 140 is a very lengthy piece of legislation, a great number of items are left to the regulations. It would be important to include a process of consultation with stakeholders. We understand that public consultation on regulations has been built into other health care legislation, a recent example being the Local Health System Integration Act.

In conclusion, I thank all members of the committee for the efforts you are making to improve long-term care in the province. We hope that you will find our suggestions for amendments constructive and that you will take them into account in your deliberations. Thank you once again for the opportunity to make a presentation today.

**The Vice-Chair:** Thank you very much. We have a few minutes left. We'll divide them equally among the three parties. We'll start with Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your recommendations. I would agree: There are some reasons to make some changes to the bill. I appreciate what you've put in here regarding the mission statement and the need to take into consideration that there isn't going to be anything here that would impact the religious organization. I hope the government does make those amendments. I think they're pretty simple and would certainly address the needs of your clients. Also, of course, directors and officers—again, I agree that there needs to be something that would be similar to the Public Hospitals Act. So I would hope that the government would respond to that amendment as well. Thank you very much.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I appreciate that you said at the outset that you were not here to represent a particular client, but you do have a lot of expertise so it's good that we can draw on that.

If you think specifically about the new requirements—by that, I mean penalties—for persons guilty of an offence—directors, officers, other staff, etc.—in your experience, given you have a number of clients who work in the not-for-profit sector, what do you think the reaction is going to be from these folks if we can't get a change in this particular section?

1530

**Mr. Gibson:** Certainly the provisions do suggest that a deterrence effect may be part of the intended results. It would seem to me that it's going to create more difficulties for boards in attracting directors. It's the sort of provision which, on the face of it, is going to make it very difficult, I think, particularly for smaller com-

munities with smaller boards of directors, to attract people to serve on their volunteer boards.

**Ms. Smith:** I have two really quick questions. My first is, what is it that compels you to want to see the amendments to the bill of rights and the mission statement provisions? I don't see any kind of threat to religious organizations, so I'm a little unclear as to why you feel those two amendments are necessary.

My other is—and I'm glad that you raised this whole discussion around the threshold because, in my view, and I've had this debate—I was a lawyer; I guess you're always a lawyer—with some of our drafting team on “take such measures the board considers necessary to ensure compliance.” I thought it was a higher threshold than “take reasonable care to ensure compliance.” So I'm interested that you think it's the inverse. Setting aside the penalty provisions, just on that threshold, is that your position, that “take reasonable care” is actually a higher threshold than “take such measures as the board considers necessary to ensure”?

**Mr. Gibson:** If I may respond, I guess the question is: What is the standard, then? It would seem to me that if we look at it as being an objective standard, then to me the standard would be higher under the new legislation. I think there's some support for that in the business cases.

With respect to your first question, the mission statement for some institutions will recite the values, will recite the core beliefs, maybe refer to a founder. A mission statement for organizations like this has a lot of historical and value-laden meaning. It would seem to me that creating the possibility for mission statements to be influenced by legislation would potentially create a danger in cases where there may be third parties or those who would want to see the mission statement of their religious order be different than what it is stated to be. In those cases, I would perceive there to be a risk.

**The Vice-Chair:** Thank you very much for your presentation.

BEV BAINES

**The Vice-Chair:** We'll move now to the last presentation, by Bev Baines.

Welcome. You can start any time you want.

**Ms. Bev Baines:** Good afternoon. My name is Bev Baines. I notice that you were greeted by the Raging Grannies this morning. I hope you think of yourselves as being bid goodbye by the engaging lawyers this afternoon. We'll see whether that's your conclusion.

I am a professor of law, women's studies and policy studies at Queen's University. My expertise is in the area of constitutional law and women's equality rights. My research focuses on the Canadian Supreme Court's equality jurisprudence under sections 15 and 28 of the charter.

In my submission, I pose three questions about Bill 140: Why should this bill protect women? Is it accountable to women? How could it be changed to serve the needs of women? I will conclude by explaining that Bill



140, as currently drafted, may infringe women's charter rights.

Why should Bill 140 protect women? Studies show, and you were told this on Thursday by the Ontario Interdisciplinary Council for Aging and Health, that over 75% of long-term-care home beds are occupied by women. Some are frail, wheelchair-bound or confined to bed. Increasingly, they have moderately severe dementing illnesses. A study published in the Canadian Medical Association Journal in 1994 showed that, of seniors aged 85 or more who suffered from dementia, 70% were women.

Dementia and other illnesses such as Parkinson's and MS lead to falls and fractures which, in turn, call for complex care for residents of long-term-care homes. Complex care, whether for women or men, takes time and costs money, yet it is underfunded at this point.

Does anyone seriously doubt that if 75% of long-term-care residents were men, more resources would not be forthcoming? Elderly men, whether formerly in business, the professions or politics, would make it happen.

Unfortunately, elderly women come from a generation that taught them dependency and subordination. They are unlikely to be lobbyists, let alone to be perceived as political calendar girls. But their daughters, granddaughters, and great-granddaughters are different. They will notice how this new law portrays women. They will ask, is Bill 140 silent about their foremothers because politicians want to conceal the fact that women constitute three quarters of the residents of long-term-care homes and to pretend that this fact does not matter?

Is Bill 140 accountable to women? Regrettably, Bill 140 makes little effort to be accountable to anyone. Rather, Bill 140 is licensing legislation, but is it the licensing legislation that women need?

What we do not need is a regulatory regime that uses the exemption process to facilitate the conversion of non-profit homes into for-profit homes. Put simply, for-profit homes make their profits at the expense of their residents and workers.

To explain, both non-profits and for-profits receive the same funding, whether from the government or from residents' fees. For-profits must make their profits from these sources, while non-profits can use these sources to provide better resident care and worker compensation.

In Kingston, the evidence that non-profits offer better care can be found in the long-term-care crisis placement policy adopted by Kingston General Hospital. This policy forces patients requiring immediate placement to select three homes from the hospital's A, B, and C lists. Only one selection may be from the A list, apparently much preferred and oversubscribed. The A list contains only non-profit homes. To move patients out of the hospital as quickly as possible, the policy also compels them to select at least two more homes from the B and C lists, which are composed only of for-profit homes, in which vacancies are more frequent.

By making it possible to convert non-profit homes into profit-making homes, Bill 140 will have a negative impact on the remuneration and working conditions of

the affected employees, the vast majority of whom are women. Women comprise 90% of the hands-on caregivers and support staff employed in long-term-care homes.

How could Bill 140 be changed to serve the needs of women? I submit that the government should make three major changes to Bill 140.

First, the act must contain a province-wide standard of care of a minimum of 3.5 to four hours per day of nursing and personal care for each resident. You've heard this recommendation today and throughout the hearings last Wednesday and Thursday. This change would begin to provide the resident-centred care promised in the bill's preamble, whereas the current discretionary two to 2.5 standard is not even sufficient to protect women and men from risk, never mind to dignify residents' daily experiences.

Second, the government must commit to funding the staff required to meet this higher minimum standard of care. This commitment must ensure that that increased funds go mainly into the personal-care envelope destined to pay employees who provide hands-on care and support for residents. These front-line workers are underpaid and poorly treated in terms of their employment conditions.

#### 1540

Third, subsection 103(9) of the bill must be amended to prohibit, without exception, the transfer of a licence or beds from a non-profit to a for-profit entity. Ideally, calls for adding more beds and building more homes should be funded in such a way as to encourage more non-profit bids. In addition, there should be incentives to encourage municipalities, where homes and beds are sorely needed, to enter the bidding process. I note that the city of Kingston just refused to tender in the latest round of bids. "Why?" you might ask, and you might think of funding as being the issue.

In conclusion, does Bill 140 infringe women's charter rights? By failing to provide the standard of care, funding and non-profit accommodation that women need, Bill 140 is inadequate licensing legislation. It promises more harm than benefit to the women—and men—whose interests should be foremost in the revision of long-term-care-home policy.

The Charter of Rights and Freedoms would have us ask of this harm, does it have a disproportionate impact on women? The government's intention or motive is irrelevant. Charter jurisprudence uses a disproportionate-effects test to establish an infringement of the guarantee of sex equality in section 15. Since 75% of the residents and 90% of the employees are women, any harm inflicted by Bill 140's deficiencies would inevitably impact more harshly on women, which is sufficient to evoke the possibility of a charter sex equality challenge. Concerned women might turn to organizations such as the Women's Legal Education and Action Fund, known as LEAF, the National Association of Women and the Law, NAWL, and the Advocacy Centre for the Elderly, ACE, for advice about launching a charter challenge.

I do not advocate spending time and money on a charter challenge. I submit that the standing committee

should take action to forestall a charter challenge by recognizing the significance that long-term-care-home legislation has for women and by ensuring that Bill 140 is changed to reflect women's needs.

**The Vice-Chair:** Thank you very much, Ms. Baines. We have three minutes left that we can divide equally among the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you very much for that presentation, which was much different from others we've heard but very good.

I just want to focus on the funding, because your point number two said that any funding or increased funding should go mainly into the personal care envelope destined to pay employees who provide the hands-on care and the support for residents. This has been a critical part of the discussion during the course of the hearings because the government has argued that they have put \$700 million into long-term care. The association of not-for-profit supports for seniors has said very clearly that only about \$2,000 of that has really gone into an envelope to increase direct hands-on care for residents, and that about \$4,000 is missing if you consider the government promise of \$6,000. So a lot of the money didn't go directly into care but went to a number of other things.

If you look at that commitment to funding the staff, I would take it that it's a commitment not just to help the staff but to ensure that it's actually funding hands-on care that the direction of the flowed money takes.

**Ms. Baines:** Absolutely, it's a direction to use it for hands-on care, and support staff as well in that particular context. But it is not money for the demon of documentation that we've rightly heard about thus far, and it's money in the context in which we also heard earlier that there are four envelopes, only one of which is discretionary funding. I'm not moving to that discretionary funding envelope. It's the pay, personal support, hands-on care.

**The Vice-Chair:** Thank you. Parliamentary assistant?

**Ms. Smith:** We have the same investment in that personal care envelope, and that's where we've seen our 4,800 new staff.

I wanted to ask you about your views on the possible conversion of non-profit homes into for-profit homes. We've heard from the non-profit sector that they don't like this section that restricts the ability to transfer the beds; they want to have that ability. You're saying that

we should restrict it and not allow for any exceptions whatsoever. I would like to hear your comments on your differing views from the sector. As well, what would you do to address the situation in northern Ontario, where we have a not-for-profit that no longer wants to be in the business of providing long-term care and there are no other not-for-profits willing to step up to the plate? What would your suggestion be in that particular case, where we have beaten the bushes and can't find anyone? How do we provide the services that are necessary?

**Ms. Baines:** I think beating the bushes is a good idea, but putting more money into the entities that are trying to make this work is the best idea of all, and it's one of the reasons why I said incentives to municipalities. So, for example, in northern Ontario—and I'm not terribly familiar with their governance structure—putting more money into the local governance structure that might be able to take over those homes is the way, it seems to me, that it has to go. If you put it into the for-profit, you're going to lose money to the profit-making aspect of the enterprise. It still won't be helpful to the residents and workers.

**The Vice-Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for a very interesting presentation and some interesting points that you make here. What prompted you to put this together, I guess, to ask the question, "Does the bill protect women?"

**Ms. Baines:** Several things did. One is my mother, who is currently in a non-profit home in Kingston. But it's mainly because I'm also, in another guise, head of women's studies at Queen's, and so I have focused all my life on issues featuring women and I've always, from the beginning, asked the question, "Where are the women?"

**Mrs. Witmer:** Well, thank you very much, and I think it is important that we continue to ensure in our province that whether you're a male or a female, you do have that equal opportunity and are fairly protected.

**The Vice-Chair:** Thank you very much for your presentation.

I want to thank all the presenters today, and all the audience and the staff and members, for their civil participation. We will be adjourning until tomorrow, 9 o'clock, in Sudbury.

*The committee adjourned at 1548.*









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## Legislative Assembly of Ontario

Second Session, 38<sup>th</sup> Parliament

## Assemblée législative de l'Ontario

Deuxième session, 38<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 23 January 2007

# Journal des débats (Hansard)

Mardi 23 janvier 2007

**Standing committee on  
social policy**

Long-Term Care  
Homes Act, 2007

**Comité permanent de  
la politique sociale**

Loi de 2007 sur les foyers de  
soins de longue durée

Chair: Ernie Parsons  
Clerk: Trevor Day

Président : Ernie Parsons  
Greffier : Trevor Day



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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Tuesday 23 January 2007

Mardi 23 janvier 2007

*The committee met at 0900 in the Howard Johnson Plaza Hotel, Sudbury.*

## LONG-TERM CARE HOMES ACT, 2007

LOI DE 2007 SUR LES FOYERS DE SOINS  
DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

**The Vice-Chair (Mr. Khalil Ramal):** Good morning, ladies and gentlemen. It's 9 o'clock on Tuesday morning in Sudbury, and it's the fourth day of hearings for the standing committee on social policy to deal with Bill 140, An Act respecting long-term care homes.

EXTENDICARE FALCONBRIDGE  
FAMILY COUNCIL

**The Vice-Chair:** For this morning's session, we have 12 presentations. The first one will be by the Extendicare Falconbridge Family Council. If they are here, they can come forward. I believe you know the procedure. You have 15 minutes. You can speak for the whole 15 minutes or you can divide it between speaking time and questions from the three parties. You can start whenever you are ready.

**Mrs. Adrienne Lemieux:** Good morning. My name is Adrienne Lemieux. I am the chair of the family council of Extendicare Falconbridge in Sudbury. I have been a member of the family council since its inception in November 2003. My mother, who suffers from Alzheimer disease, has been a resident at Extendicare Falconbridge going on five years now. My father was also in long-term care until his passing in October 2002.

Extendicare Falconbridge is a 35-year-old C-class facility, whose management team and support staff are entrusted to care for 234 residents 24 hours a day, each and every day.

Although Bill 140 contains positive language with respect to resident rights, mission statements, care plans etc., I am disappointed and deeply concerned that the funding section, part VI, does not contain language to ensure that the ministry will fund homes to provide care and programs that residents, like my mother, in long-term care need today. With their frailness and multiple and complex medical conditions—many with dementia—

everyone agrees that government should be funding homes to provide at least 3.5 hours of resident care per resident per day.

I have observed, during the numerous hours I spend at Extendicare Falconbridge either visiting with my mother or attending to my family council duties, that the hands-on employees are run absolutely ragged. There is an increasing rate of staff absenteeism due to burnout and illness. When the body gets run down, it is more susceptible to colds and other types of infections. At Extendicare Falconbridge, each personal support worker is responsible for eight to 12 residents, depending on the level of care specific to the assessed needs of each resident. If two employees are off in a particular unit, personal support workers are forced to take on more residents, since they must now provide care to those residents normally assigned to the absent employees. It is an all too common occurrence that a personal aide must care for 14 or 15 residents if replacement workers are not called in or if none are available.

In part II, the residents' bill of rights, it states, "Every resident has the right to live in a safe ... environment." How safe can it be for residents to be cared for by employees who are stressed due to work overload and have to rush from one resident to the next to deliver personal care? There is barely enough time to do a decent job of bathing, dressing, tending to a resident's basic needs and completing what seems to be an increasing amount of paperwork. Many employees often work beyond their scheduled hours. They do this because they really care.

Some residents have no family and others have family who just drop them off and might come by once a year or so. Where is the time for staff to offer a little compassion, a few minutes of companionship? Where is the time for an aide to help open a gift or a birthday card for a resident who, due to diminished physical capacity, cannot open it for himself or herself?

The existing funding levels are simply not acceptable. Government needs to strengthen its funding commitment to long-term care in this legislation and then act on its commitment in the coming budget to increase funding to provide more staff so that residents can get the care they deserve in relation to their physical, medical, psychological and social needs.

I ask that you please amend this bill to include language that the government "shall" fund long-term-care homes to provide the care and services required. This includes the funding to ensure that homes can indeed

provide the restorative care programs and the activity and recreation programs that do meet the assessed needs of the individual residents. What a difference that would make.

The funding formula should also provide for the hiring of adequate replacement employees to ensure that homes are able to provide at least 3.5 hours of care per resident per day throughout each and every day.

In part V, "Operation of Homes," section 72 states, "In order to provide a stable and consistent workforce and to improve continuity of care to residents," every home "shall ensure that the use of temporary, casual ... staff is limited." I shudder to think that homes might risk sacrificing resident care or safety by not providing enough replacement staff simply to be compliant with imposed limits.

I am also very concerned about accommodation types and the ministry's copayment structure. For older homes, there are three types of accommodation: basic—four residents per room; semi-private—two residents per room; and preferred—a single-resident room. For the newer homes, there are two types of accommodation: basic—two residents per room; and preferred—a single-resident room.

My father was a resident in one of the newer homes. He lived in a two-resident room. It was a lovely, spacious room with modern decor and amenities. Since his room was classified as basic, he was entitled to a rate reduction.

My mother is a resident in an older home. She too lives in a two-resident room. Her room is very small. The painted walls, flooring and meagre furnishings look very old. It evokes nowhere near the same feelings of spaciousness and brightness as my father's room did. Given the age and existing structure of this building, it likely never could. Her bathroom is approximately 30 inches by 40 inches and does not accommodate a wheelchair. Yet, since her room is classified as preferred, my mother is not entitled to a rate reduction.

There are ward accommodations—identified as basic—at Extendicare Falconbridge with four residents assigned to them and only a very small bathroom. There are also a few preferred accommodations at this home—two persons per room—whose residents must go across the hall to access their own bathroom, due to poor building design. Other residents and even visitors often mistake that particular residents' bathroom as a public washroom.

Imagine that you are an 80-year-old female in your own bathroom, taking care of your personal business, when suddenly the door opens and you are faced with an elderly gentleman whose trousers are halfway down his knees simply because he's intending to take care of his own personal business.

Many residents who live in these older homes suffer this type of embarrassment and indignation all over Ontario. Imagine that you have lived your entire life in a comfortable home, slept in your cozy bed with warm surroundings, with your personal items that evoke many

special, pleasant memories. Then you are forced to live in an old home in a room so small that you cannot even bring in your favourite easy chair and you are told that you must bring but a few personal items. How can this government justify the existence of such substandard accommodations? How can this government justify the double standard in long-term-care accommodations? Because my mother lives in an older C-class home, which is still part of this government's long-term-care program, she pays more than what my father paid in the newer home. In fact, if you look solely at the amenities that newer homes are able to provide because they are built to today's standards, my mother gets much less.

0910

Now even the future of her home is being made uncertain, because a deadline will be placed on the operating licence that is solely related to its physical structure. There is a deadline, but there is no process or plan to address the structural issues I have mentioned.

I urge you to change this bill to provide more certainty for the future of my mother's home and provide language that ensures government will fund the upgrading of the older C-class homes. Government needs to establish an immediate and aggressive plan to significantly improve these older buildings and bring them up to acceptable, livable standards. This will ensure that basic accommodation for all residents in all long-term-care homes means no more than two residents per room and a private bathroom that you can actually get your wheelchair into.

Seldom is my mother served fresh fruit. When I approached the dietary manager and asked why the fruit served is frequently a canned product, the response was, "Fresh fruit is too expensive, and we don't have enough staff to invest the time required in the preparation of fresh fruit." A body nourished with a healthy diet of fresh, wholesome foods will undoubtedly be a stronger, healthier body. I'm told that the daily raw food allowance is approximately \$5.46 per resident per day. Would you be able to provide your family members three healthy meals plus between-meal snacks on a budget of \$5.46 per day? I know I couldn't.

The long-term-care residents of this province are our most vulnerable citizens, and they, along with my mother, deserve to live in a safe, comfortable home environment and are entitled to the very best of care.

With a history of Alzheimer for three generations in both my mother's and my father's family, it seems likely that I too will be needing long-term care sooner rather than later. If you don't fix what's wrong with the system today, what level of care can I possibly expect when I need to go to live in one of these homes? Make no mistake: The clock is ticking. The baby boomers will be filling these long-term-care beds in droves before too long. Statistics show that Canadian citizens are living longer in their aged years. They are not necessarily living a healthy longer life. More often than not, they enter long-term care and are there for many, many years. I realize that the government has increased funding to long-term-care programs over the past few years, but it



just isn't enough. There must be more funding to upgrade these older homes and to hire more staff to meet all the residents' current needs and the increasing demands of tomorrow.

I thank you for the opportunity to share my views.

**The Vice-Chair:** Thank you very much. We have three minutes left. We can divide it equally between the three parties. We'll start with Mr. Ouellette: one minute.

**Mr. Jerry J. Ouellette (Oshawa):** Thank you very much for your presentation. I happened to note in yesterday's Sudbury Star the headline "Pressure to the Breaking Point." I don't know if you noticed that or not, but it spoke about the health care system and the impact on hospitals taking in long-term-care patients as well. I don't know if you had an opportunity or if you have any experience and maybe you can enlighten the committee on what is taking place in that situation. What would happen if the health care system, the hospitals, were to remove those long-term-care patients from the hospitals and put them into the system? How would that impact the system?

**Mrs. Lemieux:** Well, certainly they'd need to build more long-term-care facilities, because obviously long-term-care-need people currently taking up bed space in hospitals is creating a crisis in health care scenarios all over Ontario in the same fashion. You'd need more space. It takes more money to provide more space, to provide the proper care. More often than not, people sitting in a hospital bed who need long-term care don't have all of their needs addressed properly or adequately because the nursing staff is there to try to heal in medical types of situations, not necessarily the wholesome care that long-term-care residents need.

**Ms. Shelley Martel (Nickel Belt):** Thank you, Adrienne, for your presentation this morning. You are right: The bill should say that the minister "shall" provide funding, and we will be moving an amendment in that regard.

You are also correct when you say that the government has increased funding, but it certainly hasn't increased to the level that it promised in the last election. The government promised to increase funding for care for residents by \$6,000 per resident, and at this point the government has actually increased it by only about \$2,000. So we have a long, long way to go to actually have the Liberals meet that election promise.

Tell me, if the government was to give \$4,000 more per resident, what do you think might happen to the care of your mom?

**Mrs. Lemieux:** I would like to think that the money could be used to have the caregivers spend a little bit more time to address her emotional needs to some degree. An elderly person suffering from Alzheimer's, as I'm sure you're familiar with the nature of the disease, tends to have a very short attention span. Often they need to be redirected or they just need someone to sit down and appease the anxiety that they create, because in their mind they're confused. More often than not, my mother is not sure where she is and why she needs to be there,

and the personal care workers and the nurses don't have the time to dedicate to sit with her for two, three, four or five minutes to try to calm her demeanour, if she's agitated, or to simply try to make her feel comfortable about her surroundings, to reassure her that she's at home—because this is her home—that she's safe, and that if there's anything she needs, she doesn't need to hesitate to ask. But more often than not, I've gone to visit and found her standing in the doorway, basically just scurrying hoping that she can stop somebody because she has a question to ask, and the staff are just running to take care of a more urgent situation. There aren't enough people to help. It takes money to do that.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Monique M. Smith (Nipissing):** Thank you, Adrienne, for coming today. We appreciate the work you're doing as the chair of your family council. Family councils are really important to our long-term-care homes.

I also wanted to let you know that we do appreciate the concerns around the situation in Sudbury and the need for more long-term-care beds. I do note that we've seen the opening of about 414 new beds since 2002, so an increase of about 47%, and a recent announcement of new beds; I think 96 new beds are going to be built in the Sudbury area.

I was interested to hear about your concern around the continuity of care provisions in the legislation. What we've heard from other families and people in the system is the concern that their family member is being looked after by different people all the time and that continuity of care is very important, especially for people who are suffering from dementia, like your mom. It's nice to have the same person in as much as possible; they know her and her personality. That is why we've introduced section 72, which would provide for the continuity of care and try to limit the number of agency staff that we have in our homes. But you seem to have a concern around that. Do you see value in trying to limit the number of agency staff in our homes?

**Mrs. Lemieux:** I wholeheartedly agree with the principle behind trying to maintain continuity of care and trying to utilize the same staff. But when staff are burning out and are off too often due to illness—because they've caught a cold, they're run down or they've caught whatever is going through the facility that day—you're forced to call in replacement staff. If the ratio of residents to personal support workers was lessened so that you could hire more staff, the staff may not succumb to infections and illnesses. That in itself would help provide continuity of care, and not having a casual person in who is basically given 10 minutes to run through the charts: "Okay, here's the care resident A, B, C, D and E needs. Robert, do the best you can." It's an overwhelming thing. So I do agree in principle, but that may be maintained if there's a higher ratio of workers to residents.

**The Vice-Chair:** Thank you very much for your presentation.

## FINLANDIA HOIVAKOTI NURSING HOME

**The Vice-Chair:** We'll move to the next presentation, by Finlandia nursing home. Welcome. You probably know the procedure. You have 15 minutes. Would you mind stating your name before you start?

**Ms. Claire McChesney:** My name is Claire McChesney. I'm the administrator of Finlandia nursing home.

**The Vice-Chair:** And your colleague?

0920

**Ms. Andrea Turner:** I am Andrea Turner. I'm the chairperson of the Finlandia Hoivakoti Family Council.

I have been the chairperson for the family council since its inception in 2005. Finlandia Hoivakoti is a 110-bed nursing home located within Finlandia Village, a four-stage seniors' residence in Sudbury that sits on a 27-acre parcel of land on the north shore of Lake Ramsey. Although the interior has a distinct Finnish flavour, Finlandia Hoivakoti is home to residents from a number of different ethnic backgrounds. It is a picturesque setting for all who live, work and visit there.

I am speaking today on behalf of the families and friends who have loved ones in the care of Finlandia Hoivakoti Nursing Home. While we're pleased to see that Bill 140 emphasizes resident safety and zero tolerance for abuse, we do have a number of concerns that focus on quality of care for the residents of long-term care in Ontario.

As a family council, we are actively involved in ensuring that the needs of our loved ones and all residents are met. What we see on a daily basis are dedicated and caring staff who run between residents in order to attend to the varying needs of each person. The government, we have been told, has allotted enough funding so that the average home provides, on average, 2.5 hours of nursing care per resident per day. This is not nearly enough, especially when the average is much higher in other provinces.

The term "caring," as we see it, refers to not only attending to the physical needs of a person but also making time for a person's emotional needs. We know first hand that these care providers are deeply committed to caring for their clients, but time constraints restrict their ability to provide adequate levels of care to individual residents. The proposed Bill 140, with its emphasis on rules, paperwork and processes, will further reduce resident care time.

One of our greatest fears with regard to Bill 140 is that it will lead to a stronger sense of institutionalization for residents, families and professional care providers. Moving into long-term care is a difficult transition for many older people because they are leaving behind a home which is familiar to them. Thus, it is important for long-term-care facilities to foster a home-like environment in order to bring comfort and enjoyment to residents and to their visiting friends and family. Subsections 77(1) through (3) refer to the posting of information, which under the proposed bill will consist of over a

dozen official and legal documents, which in our opinion will detract from the home-like atmosphere our facility is trying to create. Perhaps, beyond the residents' bill of rights and an explanation for the measures to be taken in case of an emergency, the government could allow the resident and family councils to determine what information is to be posted in the home while making all other documents available on the facility's website or by request.

A second concern we have is the government's definition of the term "restraint." Paragraph 5 of subsection 28(1) refers to the keypads on the main doors of all long-term-care facilities, which provide a safe and secure environment for all residents, as being a kind of restraining device for those residents unable to punch in the code which opens the main door. There seems to be a fine line between paternalism and autonomy here. We do not let young children, who are just as vulnerable as a cognitively impaired adult, wander unattended out the front door of their homes, and we certainly don't label our children as "restrained citizens" either. Defining perimeter security as a form of restraint could potentially have a negative emotional impact on all residents, thus making long-term care feel more like an institution than a home.

What makes each long-term-care facility less institutional and more home-like are the unique personalities of each resident. Every long-term-care home, like every other home in Ontario, has a flavour of its own. The regulation and prescription of mission statements and volunteers, as outlined in clauses 4(1)(a) and (b), subsection 4(3) and subsection 15(2), detract from the unique character of each home. Legislating a defined list of volunteers takes away the freedom to address the needs of the current residents. Suggestions and guidelines would be a far more valuable and reasonable way to approach volunteerism because long-term-care homes, although they may try to acquire representatives from various parts of the community, first must ensure that these volunteers speak to the needs of their residents.

As a family council, we recognize the negative effect non-compliance by the facility has on our loved ones, and so we support the government's efforts to make long-term-care homes and their staff responsible caregivers. Subsection 146(3) states that all non-compliance is to be documented. Filing formal reports, and having them processed, responded to and cleared, however, takes valuable time away from resident care. Our fear is that staff will become more task-oriented, focusing more on compliance issues than caring for our loved ones. As previously stated, we see that the staff are run off their feet as it is. Filling out paperwork for a slippery floor hazard caused by a resident's spilt juice, which gets cleaned up immediately, will take away from the already too-little allotted nursing care hours.

Funding penalization for non-compliance, found in section 152, has also raised some concern because we feel it will detract from resident care. Withdrawing a home's funding for non-compliance reminds me of international economic sanctions. It is not the bureaucrats



who suffer the consequences; in this case, it will be our loved ones. If the government were to force the owner/operator to hire an outside expert to assist the facility with compliance, at the operator's expense of course, the home would maintain the standards of living and safety for the residents while working on its compliance issues.

Along with our plea to reconsider funding penalization, we feel it is absolutely necessary that the government maintain and/or improve upon its financial commitment to resident care. Subsection 88(1), however, outlines that the government has removed its commitment to resident care. Bill 140 reads that the government "may" fund long-term-care homes, whereas existing legislation reads that the government "shall" fund long-term care. Word choice is important. If owners and operators of long-term care are obliged to meet the expectations of Bill 140, then the ministry has an obligation to provide adequate funding to enable the home to meet the quality of standard set forth by the ministry. The family council feels quite strongly that the role of the governing body is to steer owners/operators in a direction most beneficial to the residents, but that can only come from sufficient funding.

Long-term-care facilities are home to a growing number of older adults. It is important that this new legislation not only protect our older family members and friends, but also create an atmosphere where those who have chosen to care for older people in need can do so in the most beneficial way possible for the residents who call long-term care home. We urge you to remember that what our loved ones need most is to be cared for in a holistic sense. Thus, we ask you to be mindful of the increased paperwork, processes and a doctrine of absolute compliance which are sure to lead to a stronger sense of institutionalization for the residents and where the term "care" will become task-oriented, as opposed to our loved ones living in a home-like setting where care is understood through the quality time staff spend with individual residents.

In addition to the issues raised in our presentation, we urge the committee to support the detailed amendments submitted by the Ontario Long Term Care Association.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left; we can divide them equally. We'll start with Ms. Martel, one minute.

**Ms. Martel:** Thank you very much for your presentation this morning. Just a couple of points and then I have a question.

You're right: It's interesting that the current legislation before us has "may" instead of "shall," and one wonders how that happened and why. We will move an amendment that will say "shall" again.

Also, when you talk about section 77 and all the paperwork, it's interesting that the government also says that any regulated documents have to be certified by a lawyer. I don't know what that's going to mean in terms of the documents you have in the home and that whole process as well.

Looking at all of the increased obligations, what's your concern with respect to resident care when you look at the bill and you look at all of the new obligations and requirements that are going to be put on the home?

**Ms. McChesney:** If I may, I think our genuine concern is that all of this detracts from the care of the resident. One of the things that we are trying very hard to do is to maintain, as well as try to enhance, the physical and mental fitness of our residents. That's virtually impossible to do as we get more and more bogged down with the paperwork that's required. The hours that should be going to that type of care, then, are being taken up by this type of thing.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** I just wanted to follow up on that point on the paperwork. With regard to subsection 146(3) that you were concerned about—documentation of non-compliance—it's actually the inspector who comes in and does their annual inspection who must document non-compliance, not the home. And there's no obligation in this legislation to require that a home document a slippery floor when the juice has been cleaned up. I don't know where that came from. It was talked about last week. There's no obligation. In fact, the paperwork obligations that are in the legislation reflect what is for the most part already in the guidelines and the policy manual. There are a few around restraints—I know that you've addressed some of it around the security of the homes—that do add some paperwork. The documentation that we're requiring is really to ensure resident safety and that we are focusing on a resident who is in restraints and ensuring that the use of restraints is limited to very specific circumstances. I just wanted to try to address that concern.

At the end of your presentation—which I really appreciated; thank you—you talked about loved ones and the approach being holistic. I'd just point out to you that in the plan of care, we've really tried to ensure that everyone is involved in developing a plan of care, that it's resident-focused and that it's multi-disciplined so that everyone who has a role to play in that resident's care is involved in developing a plan of care, including the family members or someone of significance to the resident. I take your points, and I thank you for the work that you're doing on the family council and for running a great home.

0930

**The Vice-Chair:** Thank you very much. Mr. Ouellette.

**Mr. Ouellette:** Thank you very much for the presentation. I just want to continue on about your concerns with the amount of paperwork. I know in the past that, for example, the health care system was given funds to hire nurses. However, the nurses didn't provide patient care; they ended up doing data entry. I think what I'm hearing is that basically the same sort of thing may take place here. What do you think an adequate level of hours would be, as opposed to 2.5 per day, to take care of the paperwork as well as increase the level of care?

**Ms. McChesney:** At this point, we certainly have discussed moving to at least three, but when I'm talking about three hours of care, I'm talking about the care to the residents. That does not in any way touch on any hours that are spent doing the paperwork.

**The Vice-Chair:** Thank you very much for your presentation.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1623

**The Vice-Chair:** The next presentation will be by Dave Shelefontiuk. Welcome, sir. You have 15 minutes. You know the procedure, I believe. You can start when you are ready.

**Mr. Dave Shelefontiuk:** I'd like to thank the committee for letting me speak today. On my right is Brian Blakeley; he's CUPE research. I'm Dave Shelefontiuk. I'm the president of Local 1623, the hospital workers.

The Canadian Union of Public Employees, Local 1623, represents approximately 1,000 support and clerical employees at the Sudbury Regional Hospital, including both full-time and part-time employees. On behalf of those members, we would like to thank the committee for making time for us to speak today.

Committee members are likely aware that CUPE and Local 1623 are strong supporters of public health care and public hospitals. Thanks in part to the struggle of working people, hospital services are protected by the Canada Health Act and its five principles: universality, comprehensiveness, reasonable access, portability of coverage and public administration.

Unfortunately, many other health care services do not receive such protection. It is alarming that the hospitals are playing a smaller and smaller role in health care. We understand that a recent report from the Canadian Institute for Health Information has reported that in the mid-1970s hospitals accounted for 45% of total health care, but by 2004 only 30% of total expenditures went to hospitals, which is a pretty big decline.

It is the policy of the provincial government to move services out of hospitals and into the community, be it home care, long-term care, clinics etc. While we, as hospital workers, recognize that in some, but not all, cases this is appropriate, we are concerned when we see that such changes are a rather thin disguise for reducing the level of care to patients.

Across the province, thousands and thousands of hospital beds have been eliminated since the early 1990s. It is now widely recognized that a lack of beds is a key factor causing very high bed occupancy levels, helping to create an ongoing crisis in emergency rooms, forcing the cancellation of surgeries, creating unacceptable wait times and encouraging the outbreak of superbug infections in our hospitals. A recent example of that is the Norwalk virus, which is very prevalent here in Sudbury.

There has been a very serious bed shortage in the Sudbury area for some time. We have attached some

newspaper clippings to this brief illustrating this crisis. Part of the problem, we believe, is a lack of hospital beds.

A recent example of the wait times is that I took my mother-in-law into the emerg last week. She waited in that emerg on a stretcher for two and a half days before a bed was even made available.

As in other hospitals, we have seen our beds cut. I'd like to draw your attention to one specific area of bed cuts. There used to be 64 complex continuing care beds, or, as they used to be called, critical chronic care beds, in the hospital. This number has been reduced to 26.

Complex continuing care beds have been cut not just in Sudbury but across the province. If they are replaced at all, it is with long-term-care beds. But complex continuing care beds are funded at a much higher level than the long-term-care beds, so when you replace complex continuing care beds with long-term-care beds, there are fewer resources to provide proper care.

Earlier, CUPE looked at this transition and found that these changes had a very serious impact on the level of care. CUPE initiated a survey in Ontario of workers in complex continuing care hospitals and a former complex continuing care hospital that was changing into a long-term-care facility. The survey was developed by front-line health care employees working in conjunction with CUPE research and sociologist David Hubka. The study assessed the impact of funding cuts on workload and patient care and provided a voice for front-line workers in these facilities. The study provided a comparison of respondents from a facility that was undergoing the transition from complex continuing care to long-term care and hospitals that still provided a complex continuing care environment. The government was turning the Perley and Rideau Veterans' Health Centre into a long-term-care facility. At the time of the study, funding at the Perley stood approximately halfway between complex continuing care and long-term-care funding per resident.

Respondents at the Perley usually noted more workload problems. They were more likely to report working before or after hours without pay: 73% versus 53% at the surveyed hospitals. They were more likely to report working during their lunch period: 67% versus 54%. They more often reported that they were doing more unpaid work than four years previously: 54% as compared to 45%. They were more likely to report that their workload is increasing: 100% versus 90%. They were more likely to report that their workload is hurting their health: 86% versus 77% of respondents at the hospitals.

Similarly, respondents usually noted more quality of care problems. Perley respondents were more likely to report that patients have one tub bath or shower per week or less than respondents at other facilities. Perley respondents were more likely to report that they have patients who seldom get out of bed due to a lack of resources. They were more likely to report having patients who do not get out of bed due to a lack of exercise: 76% versus 57%. Some 44% of Perley respondents report



that this is an increase from four years earlier, compared with 34% of other respondents. They were more likely to report that they had less than five minutes per day to talk socially with each patient. They were more likely to report that they had less time than four years ago.

Overall, these findings suggest that funding cuts and the resulting staffing shortages have a measurable impact on the quality of care provided in chronic care hospitals.

We've attached a copy of the Perley report.

These sorts of changes continue to happen here in Sudbury, with the attendant cuts in care.

0940

Until recently, the Sudbury Regional Hospital had 37 long-term-care beds. The recent announcement of 10 long-term-care beds made that 47. They now have reduced that number to 26. This has resulted in five nursing staff for these beds during the 12-hour day shift and three for the 12-hour night shift. That is a total of 96 hours of staffing per day. That means that each resident is allowed 3.7 hours of direct nursing care a day. These are difficult shifts to work. The staff find the workload challenging and sometimes unbearable. We've filed workload grievance after workload grievance and nothing gets done.

We find it difficult to believe that quality care can be provided at a long-term-care facility with less than three hours per day of nursing and personal care. We know that many of the CUPE members who work in long-term-care homes do not believe that even that level of care is provided. We do not believe it appropriate that these or any other services be moved out of hospitals to cut the care. But all too often, it looks like that is at least part of what is going on. We believe that there is an urgent need for minimum staffing standards. We urge this committee to propose a minimum of 3.5 hours of nursing and personal care per resident per day to start.

On behalf of the members of CUPE Local 1623, I'd like to thank the committee for hearing us out.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We'll start with the government side.

**Mr. Jeff Leal (Peterborough):** Thank you very much, sir, for your presentation, with your background. My question for you: There's been a lot of discussion while we were in Kingston yesterday about how to define the components of the 3.5 hours of direct care. We heard a number of ways that that could be attained. I'd just like to get your view. You're a front-line worker. You have lots of experience. How would you define those components that make up the 3.5 hours?

**Mr. Shelefontiuk:** I look at 3.5 hours as being direct nursing care. If you combine as recently heard on the news that in Kingston they assessed that it costs \$1,400 or \$1,500 a day to run per patient, and if you look at 3.5 hours, that's 3.5 hours of direct nursing care. That's not including the dietary staff or housekeeping staff. I think to get a more personalized view with the residents, the nurses need to be there at 3.5 hours.

**The Vice-Chair:** Mr. Ouellette.

**Mr. Ouellette:** You specifically mentioned in your presentation the five nurses who provide 3.7 hours. The legislation enshrines the mandatory RN. Do you believe that there should be a ratio of RNs to the number of patients? I don't see anything that specifically states that. The RN could be handling from large numbers to small numbers.

**Mr. Shelefontiuk:** Being CUPE, which represents registered practical nurses, the short answer to that is no. I believe that a registered practical nurse is equivalent to an RN.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for providing the comparison of what level of care is required for chronic care patients in a hospital, and that even the 3.7 hours that you calculated is not enough. When you look at some of your colleagues who work in long-term-care homes, you're finding it hard to imagine how they're able to provide any care at all. Maybe you can give us an idea of what you hear from some of your colleagues who are working in some of the homes locally about the care they're expected to provide and what they're realistically able to do.

**Mr. Shelefontiuk:** I can tell you just briefly what my understanding is, but I'm sure when they follow up, they'll present a better case than I will. My understanding is that they don't even have time to sit and talk to the patients or work with the patients. They're running and running just to get a bare minimum of stuff done. As far as the cleaning part goes, there have been recent outbreaks of Norwalk. Being long-term-care residents, they're not leaving their beds as often as some of the others, like hospital patients. So the cleaning standards, with the money they're getting—they're just doing the bare minimum; nursing standards—bare minimum; dietary—bare minimum. That's my understanding.

**The Vice-Chair:** Thank you very much for your presentation.

JOANNE GRAHAM

**The Vice-Chair:** We'll move to the next presentation, by Joanne Graham. Is Joanne Graham here? Welcome. You can start whenever you're ready. I believe you know the procedure. You have 15 minutes. You can speak for all of the 15 minutes or you can divide them between speaking and questions.

**Ms. Joanne Graham:** During my presentation I'm going to mention time frames. These time frames, implemented by the Ministry of Health, are from your last meal of the day to your first meal in the morning, and from your first meal in the morning to your nourishment, to the middle meal; time frames as in positioning of residents, whether it's every hour or every two hours, depending on the resident, depending on the location and everything.

Who am I? What do I know about long-term care? Well, I'm Joanne Graham. I am from a small town up north called Kirkland Lake—population 10,000. I've

worked in this field as a caregiver most of my life. I have seen long-term care come from next to nothing to where it is now. Let's not stop till it is what it should be: great.

I am sure you will hear many reasons during these hearings why we need more funding. We are only a few voices for many who can see that 3.5 hours are needed. I hope that I will give you a different look into the needs of long-term-care residents. Who are these seniors? They are people I have known all my life. They are someone's hairdresser, teacher, doctor, someone's mother or father; people who have been sent from hospitals that have downsized, from the psychiatric hospitals that are closing. We have group home people who don't fit into the group home setting because of age or behaviour. These elderly ones are confused, with different illnesses from Alzheimer's, frontal lobe damage, depression, schizophrenia, Korsakoff's and more, illnesses that we are only learning about how to live with now—all these residents in the same place with all these mixed feelings, mostly fear. And with fear comes lashing out.

Most seniors have been through hard times—the war, hunger, moving to this great country of ours, doing without so we can do with. All these hardships don't just disappear because times have changed, as the caregiver knows only too well. The caregiver tries to meet the needs of all her residents. She calls to the registered staff—the doctors, the gerontology doctor—for guidance. She is faced with time frames, and the ever-so-kind words from the doctor: "Approach in a calm manner. Take your time. Let the resident be aware of their surroundings." The chemical restraint is not popular. Don't get me wrong, the caregiver is not for restraint of any kind for it only makes their job harder. Safety of others is high on the caregiver's list—so many residents, so many different needs, so few staff.

The night shift, with only a few staff: positioning of residents who are unable to; making sure the resident is dry and comfortable; doing night-shift cleaning; looking for the elderly woman's lost child—she is in the past, but we are in the present; the war hero who relives every night the terror of war; the 60-pound man yelling, "There's a woman in my room"; holding the hands of the dying. Yes, we are peacekeepers, pastors, cleaning staff. A lot of the time we are the last face they see. We go without breaks to stay with the residents to keep them safe from themselves, or just to be with the resident whose needs are greater than ours.

The evening shift—a shift that very few want to work: Sundowners and other behaviours increase greatly. Gentle reminders, a light touch—slow and easy is how to go. But there are these time frames again. The noise from one resident will start angry outbursts from another. If you had the time, you could see the behaviours multiply. On the evening shift families come to see their loved ones. They want to know how they can help to bring their loved ones back in time so they could be as they once were. Families' needs are great as well. We give comfort. They cry; they get angry; they demand results. I often hear, "My father never did hit out before." But he does now.

#### 0950

Day shift: Only one hour to get the residents up, washed, looking good, transported to meals, fed—toilet activities, bathing, nourishment and appointments. Let's not forget charting: intake, output, skin assessment, circulation, good colour/poor colour, meals, supplements, walking—did they walk, did they not walk—anger/no anger. So many difficult residents in one place.

We haven't even spoken about the residents in our home going back to their original language—Polish, Russian, Finnish, German—on and on it goes. Communication takes time, and there is no time because we have time frames to meet.

As you are aware, we the caregivers have a hard job. Who doesn't, nowadays? A caregiver can be spit at, hit, sworn at, tossed around like a playtoy several times in a day, depending on the day. What worked yesterday may not work today. We all know it is the illness, not the person, but it takes time to find out what will work. We all know that different diseases have different stages and different behaviours, from early stage/middle stage/late stage. These diseases are different challenges. And there's no time. We have worked without relief for staff for years. The staff can't even get time off when they need it. The staff don't stay. The work is too hard with not enough staff. The people would like the type of work in long-term care if they had the time to do their job. We were at 2.25 hours years ago, and that wasn't enough. We've never seen that since.

Please understand: Staff go without breaks. They get degraded at times. They do things that are unsafe, like rushing. This rushing is not so they can sit; they rush so they can spend time with the ones who need it the most.

I ask you: At 3.5, give our elderly dignity during the last part of their life. That's it.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We can divide them equally among the three parties. We'll start with Mr. Ouellette.

**Mr. Ouellette:** Thank you very much for your presentation. At the start of your presentation, you mentioned about the group home settings aspect. Are you sensing that there should be specific homes for specific illnesses or needs for long-term-care individuals?

**Ms. Graham:** I'm only a health care worker and I don't know, but I do know that you need the time to approach these people. You cannot approach them in a hurry. We need doctors to come in and assess and give us some guidance on how to deal with these people. We don't have the doctors. We don't have the time.

**Mr. Ouellette:** To continue on, then, on that train regarding the amount of time, do you believe, as I stated to the last presenter, that an RN is required? It's established, but it doesn't state the level of care, so an RN could be for a small group or a large group. Do you think that there needs to be an assessment based on the number of individuals who are being taken care of?

**Ms. Graham:** I think the assessment should be on the care the resident needs at the time. In our home, and



that's only what I can deal with, what comes out of the nursing budget is certainly not all hands-on care. The dietitian who comes up and charts—that portion comes out of the nursing budget. The office girl who comes up and makes appointments and does scheduling—that comes out of the nursing budget. We also have the DOC who comes up; the RN who does a lot of paperwork. We have the RPN who does the medication. All of this comes out of the nursing budget, but the actual hands-on care is limited. Certainly I'm not saying that they are not needed or are not a big asset, but the actual hands-on care is very much limited. It seems to me and my coworkers that we are taken last as far as looking into what the needs of the residents are, when we should be looked at first and foremost.

**The Vice-Chair:** Thank you very much. Ms. Martel?

**Ms. Martel:** Thank you, Joanne, first for coming from Kirkland Lake, because that was a long way to come to make your presentation, but secondly and more importantly, for the presentation that came right from the heart. Thank you very much for doing that.

You focused on the fact that you don't have enough time. In response to my colleague, you pointed out some of the things that are included in the nursing envelope that strictly really aren't hands-on care. I've been advocating for some time that the legislation clearly state and have a provision for 3.5 hours of hands-on care. Right now there isn't any rule about how much care can be provided. There used to be, when the NDP was the government; it was cancelled by the Conservatives. The Liberals promised to put a standard of care back in, but they haven't. What could your coworkers do if there was actually a rule or a law that said that a minimum of 3.5 hours of hands-on care had to be provided to your residents every day?

**Ms. Graham:** Certainly I think the home would benefit by this. The residents would be more comfortable. They would have more of a bond with their caregiver. We do have primary care where a staff person has the same residents every day, so we try to deal with that. But to pass somebody and say, "I will be back in a minute," and know that you are unable to—I think that would solve the problem of dignity for the people at their last stage of life, which is a must. I think that certainly would help.

**The Vice-Chair:** Thank you very much. Parliamentary assistant?

**Ms. Smith:** Thanks, Joanne, for coming, because Kirkland Lake is a bit of a trek. What home are you at in Kirkland?

**Ms. Graham:** Extendicare of Kirkland Lake.

**Ms. Smith:** Great. I just want to touch on two things that you brought up. You talked about the fact that the health care aide/personal support worker spends a lot of hands-on time with the resident and you talked about their role in resident care. I just wanted to point out that in our plan of care in the bill, we are setting out that all those involved in the care of the resident have to be involved in the assessment and developing of the plan of

care. So it's definitely creating a role—in some homes, it did exist; in some homes, it didn't—so that the personal support workers or the health care aides are involved in the assessment and then in the drafting of the plan of care.

But I did want to focus in on the 3.5-hour question and what you would include in 3.5, because I was interested in your discussion with Mr. Ouellette about what is included in the nursing envelope. You noted that the RPN does medication and that there are others who are included in that nursing and personal care envelope. In the 3.5 calculation that you're seeking, who would you include?

**Ms. Graham:** I certainly would include the RPN who hands out the medication and the personal support worker who does the hands-on care, and I think the others should be in administration.

**Ms. Smith:** Okay. Thanks.

**The Vice-Chair:** Thank you very much for your presentation.

#### LYNN GRANATIER

**The Vice-Chair:** Next would be Lynn Granatier. Welcome, Lynn.

**Ms. Lynn Granatier:** Thank you. My name is Lynn Granatier. I'm also from Extendicare Kirkland Lake. I've been with Extendicare for probably 10 years. I am a PSW; I'm the front-line staff.

"Dear," came the fragile voice from behind the privacy curtain, "Come here. Hold my hand. I'm scared. I've just been here for a couple of days. Everything is so strange and scary here." The thoughts that are crossing my mind are: "I've got one resident sitting on the toilet; I've got two more residents waiting to get to the bathroom with the mechanical lift; I've got another resident in bed, waiting to get up for lunch—all this before I can go on my break. This old woman is not my resident. I have to take 10 minutes out of my precious time to comfort this poor old woman." What a sad, but true, story.

#### 1000

When I started working at a nursing home, my grandmother was alive. She was so proud of me. She told me I was going to be able to help the old folks. She has now passed on, and I try to treat my residents the way I wanted people to treat her.

Here's the truth: I am one person. I have eight people to care for. They need me to do total care for them: wash, dress, feed, bathe, toilet, change their briefs, put them down for a nap. Nowhere in my schedule is there time to meet their emotional needs. I work on a floor where there are a lot of residents with cognitive impairments. These people need one-on-one time that we just do not get. With the lack of this time, there are many, many behaviours that are dealt with by restraints, either chemical or physical. I ask all of you: Is this the best we can do for our seniors? Is this the respect we owe them? You and I will be their age in the not-too-distant future. I hope I will never end up in a nursing home. I hope you never

end up in a nursing home. But if you do, are you going to be happy with the decisions you are making?

Thank you.

**The Vice-Chair:** Thank you very much for your presentation. I guess we have lots of time for questions. We have about 10 minutes, and we can divide them equally. We'll start with Ms. Martel.

**Ms. Martel:** Thank you very much for your presentation and for coming, again, from Kirkland Lake. I assume the two of you came together.

**Ms. Granatier:** Yes, we did.

**Ms. Martel:** That's good. A safe journey back.

You've been with Extendicare for 10 years. Can you tell the committee what changes you've seen over that 10-year period in terms of staffing, the level of care that residents require etc?

**Ms. Granatier:** Where to begin? I know that workloads have increased incredibly. We have been given more chores for less time, and when I say "chores," it's a terrible way to put it, because we're dealing with people.

With the increased two baths a week, it has increased our workload enormously, because when you increase the bath, you're talking about behaviours, you're talking about someone who may not want to have a bath. So you have to approach all of these with kid gloves.

Feeding is another thing. At my particular table, I have a group of eight people. I feed three people at my table, each and every one of them with individual needs.

I could go on and on with the increased needs and the lack of time that we have.

**Ms. Martel:** When you talk about the two baths per week and what that means, because you could have residents who are fighting that very aggressively—

**Ms. Granatier:** Oh, definitely.

**Ms. Martel:** —was there a staff increase to allow that to happen, and are you actually able to provide baths versus what has been referred to as a "bath in a bag," which is more of a sponge bath?

**Ms. Granatier:** We at our home really do try to do our baths. I'm sorry; what was the first question?

**Ms. Martel:** Did you see an increase in staff? You've said this increased your workload. Was there some kind of increase in staff—another part-time person, another casual person who came in?

**Ms. Granatier:** When we had the one bath a week, I was a bath girl, and I really enjoyed that job, but with the increase to two baths, the bath positions disappeared and we did have one more full-time staff. But that took the job of two bath girls. So, yes and no; we had a transfer of positions.

**Ms. Martel:** In terms of the residents you are caring for, you talked a little bit about baths and some of them not being comfortable with that. How many of them are mobile, for example? You talked about the number that you need for feeding. I'm assuming that's not tube feeding.

**Ms. Granatier:** We have at least 27 feeders on our floor, probably 25% mobile, 75% of whom use a mechanical lift.

**Ms. Martel:** And in wheelchairs?

**Ms. Granatier:** Oh, yes. With the wheelchair, we have to use the mechanical lift to put them in the tubs or to put them in the showers. So, yes.

**Ms. Martel:** Okay. Thank you.

**The Vice-Chair:** Ms. Smith.

**Ms. Smith:** I appreciate, Lynn, that you came as well. Thank you for being here and for your presentation.

I just wanted to ask you, because you're a front-line worker and you can tell us a little bit about this: We've had different comments about this "bath in a bag" question. It's my understanding that some of the residents prefer a sponge bath to the discomfort of going into a full bath, so sometimes for those residents a home will choose to do one sponge bath and one full bath in order to meet the needs of the resident. Is that an accurate description in some cases?

**Ms. Granatier:** The people who have a hard time with the bath are probably the cognitively impaired people. So it's the people who don't know any better that we have to make decisions for, and that's why they're there. If they are extremely resistant to having a bath, it's not worth putting them through that, but sometimes it's better for them to have a bath than to not have a bath. In our home there are very few cases when there's a bed bath given, as opposed to the two baths.

**Ms. Smith:** I wanted to ask you the same question that I asked Joanne, and that was about the 3.5 and what you would see included in that number. We talked about the different people who have involvement and interaction with the residents and what they would see as being included in the number of hours of care.

**Ms. Granatier:** I would be really selfish there and say probably PSWs and maybe RPNs.

**The Vice-Chair:** Mr. Ouellette?

**Mr. Ouellette:** Thank you very much for your presentation. You mentioned that you take care of eight individuals.

**Ms. Granatier:** Yes, I do.

**Mr. Ouellette:** Can you give a breakdown of how you feel that those individuals would receive the current 2.5 hours of care? You being one individual, obviously there are other individuals who provide that care for them throughout the day. Can you just give us a breakdown of how it operates in your facility?

**Ms. Granatier:** There are some individuals who need more care than others, and, unfortunately, the ones who need less care get less care. The ones who need more care, obviously, you have to take away—our home is not 2.5. I believe our home was broken down to 1.91. So they don't get that. But, yes, some of the individuals who can care—well, we don't really have any who can care for themselves, but the ones who can do more for themselves get less care than the ones who have to have more care.

In the 2.5 hours, you have to remember that we have mechanical lifts that we have to deal with. That means we need two people to do that. So again, we're taking two people to do one resident, and that cuts into our time as well.



**Mr. Ouellette:** So what would be an adequate level at your particular facility, then, if you're at 1.91 and you're having a difficult time complying with that?

**Ms. Granatier:** What would be an adequate level?

**Mr. Ouellette:** Yes.

**Ms. Granatier:** Three point five hours.

**Mr. Ouellette:** Even at the 3.5, we've heard about the amount of paperwork that potentially could occupy you. Some of the concerns are that, as opposed to patient care, you end up doing part of your 3.5 just providing paperwork. It's administration. Do you know of any particular way to ensure that that is not one of the ways that those things happen?

**Ms. Granatier:** The paperwork is important, because if it's not written down, it didn't happen. We have to have a way of tracking what we do. But I don't think a maximum of paperwork is necessary for us front-line staff. I think that with the increase or a full RN, we should be able to relay a lot of the stuff that happens to the RN and have them do the paperwork.

**Mr. Ouellette:** So somewhat of a funding model that separates administration from patient care would be one of the ways to go to ensure that patient care is met at an adequate level, as opposed to administrative dollars, as we heard earlier on—some of the nurses' funding envelope taking care of other aspects, as opposed to just nursing care.

**Ms. Granatier:** That would be excellent.

**The Vice-Chair:** Thank you for your presentation.

#### EXTENDICARE CANADA

**The Vice-Chair:** We'll move to the next presentation, by Extendicare Canada. Welcome, sir. You can start when you're ready.

**Mr. Keith Clement:** Good morning. My name is Keith Clement, and I'm the regional director for Extendicare Canada for northern Ontario. I'm located at the Extendicare York facility in Sudbury, Ontario.

I would like to firstly thank the members of the standing committee on social policy for giving me the opportunity to comment on Bill 140, the new long-term-care act introduced by the Liberal government.

Let me provide you with some of my background in terms of my experience in long-term care. I have 17 years of experience working in long-term care in Ontario in different roles, seven years as a social worker at our 234-bed Extendicare Falconbridge home in Sudbury and nine years as the administrator of the same home. In 2005, I was transferred to Extendicare York, our 288-bed home in Sudbury, Ontario, and have recently accepted a regional director's role with Extendicare. In my current role, I oversee the operation of eight long-term-care homes in northern Ontario. In total, we care for over 1,129 residents in the north, and we employ over 900 long-term-care employees at these homes.

1010

I believe I bring to you today some experience in working in long-term care and, through these experi-

ences, a perspective on some components of this act that I support and other areas that I believe must be changed.

Most importantly, though, I have a grandmother who resides in a long-term-care home in Sudbury. My grandmother is over 80 years of age and left Dauphin, Manitoba, over 60 years ago to come to Sudbury to start a family and contribute to the well-being of this community. The long-term-care home that she lives in provides excellent care with the resources that they are given. My family and I are appreciative of the care that she receives.

I'm sure that my submission today and the issues and implications that I bring forward to your committee are not new. My hope is that, by reaffirming and bringing forth these points, the government will listen to different perspectives and act on changes that improve the legislation even further.

I wish to comment on some areas of the act that are positive in nature and that in many cases complement the language in the existing Long-Term Care Act. Clearly, the abuse and prevention language is an important part of ensuring that residents, families and the public are assured that everything possible is being done to protect and ensure the safety of our loved ones. We operate within an environment of frail and vulnerable individuals, and any opportunity that we can create to ensure safety and respect for our residents is an opportunity we cannot afford to miss.

I am also proud to say that in the homes I'm accountable for, the concept of least restraint is one that we not only promote but insist upon. We need language within the act that encourages long-term-care homes to look at every option prior to utilizing restraints. Beyond this, if restraints are necessary as a method of last resort, processes and checks should be in place to ensure the safety and respect of our residents. Restraints should be the exception, not the rule, in long-term-care homes in Ontario. I'm encouraged that this new legislation builds on past standards to ensure the philosophy of least restraint becomes part of our culture in long-term care.

The residents' bill of rights is emphasized in the new legislation and identifies residents' rights as an important expectation of consumers of long-term care. It sets out a framework by which residents should expect to be treated in long-term-care homes. No one can dispute that our residents should be treated with respect and dignity, and the residents' bill of rights is central to this concept.

Of importance to note is that there are also some components that were always in the existing act. As operators, we were obliged to meet these standards on a day-to-day basis prior to these hearings. We're obliged, for example, to ensure a safe and secure environment; to develop individualized care plans; to have complaint policies and procedures in place; to implement quality management systems; and to implement infection control programs in the home. These are but a few examples that the act includes that our residents and the public should expect from long-term-care homes in Ontario.

There are three points I wish to make today related to the act that I would like this committee to consider

making changes to for the benefit of those who reside in our homes.

Our current funding levels are not appropriate for the care that needs to be provided. I acknowledge that, as a government, there have been increases in the funding levels for long-term-care homes. We've seen some positive movement in this area and our care and program envelopes have seen increases. However, much of these announced government increases has been required to operationalize the 20,000 new beds that the province developed over the past several years to meet the growing need for long-term care in the province.

On average, our residents receive 2.5 hours of care per day. This remains too low in light of the increased complex issues that we're expected to meet on a day-to-day basis.

The Ontario Long Term Care Association has outlined to the government a need to increase funding based on comparable data in other jurisdictions and the increased care needs of our residents. I support their recommendations even more strongly in light of the expectations that are outlined in this new Long-Term Care Homes Act.

More troubling is the fact that, although the government outlines in the legislation specific programs that must be provided by the home, the legislation as written is unbalanced as it does not give equal obligation to the minister to provide funding to the home.

Subsection 88(1) should be replaced with, "The minister shall"—not "may"—"provide funding for a long-term-care home consistent with section 1 to provide care and services required in part II."

The government has missed an opportunity, I believe, to instill more confidence in our residents, their families, our staff and the public by not placing the level of importance that they should on the funding model and the need to correct and enhance funding in long-term-care homes in Ontario in this legislation.

I also recognize the importance of documentation in long-term care, as our system is based on providing care on an individualized basis. Assessing, evaluating and communicating these needs is an integral part of ensuring that our residents are receiving the best possible care. There needs to be a balance between the expectations placed on documentation and the need to promote hands-on care for our residents. Too often over the years I've heard how onerous the documentation requirements are in relation to meeting the provincial standards. This legislation creates some more processes and requirements for documentation. For example, for many of the requirements of Bill 140, it's not clear how an inspector will be able to identify compliance with the act without the home setting up a paper trail.

Subsection 18(3) requires communication of zero tolerance of abuse in the abuse policy on a regular basis to everyone attending or visiting the home. Homes will have to print off and circulate these policies on a daily basis and can only demonstrate compliance through the tracking of distribution—for example, sign-off sheets by recipients.

Sections 28 to 31 set out the requirements relating to restraints. The existing policies of the home will have to be revised and updated and then verified to be in compliance by inspectors. Ongoing documentation is required to demonstrate that each element of these sections is met. This is not because there is widespread use of restraints, but rather because Bill 140 establishes perimeter security, secure units, locked elevators etc. as "restraints," and most PASDs meet the definition of "restraint" set out in section 28. In a 100-bed home with a perimeter barrier that is a restraint for 65% of the residents, monitoring, assessment and reassessment of these 65 restrained residents will have to be documented on a daily basis. Under current standards, a resident in a restraint must be checked hourly, with the corresponding note in the care plan to demonstrate that the check was completed. This potentially translates into 569,400 documentation entries in a year. It takes about 10 to 15 minutes to complete a check and document it. Over a one-year period, this translates into 142,350 hours or 73 full-time equivalents of time to document only those 65 residents who are restrained by the perimeter security.

Clearly this is not the intent of Bill 140, and the current hourly checks were not specifically intended for perimeter barriers. However, even with one daily check per resident and corresponding documentation time to provide proof for the inspector, 5,932 hours or three full-time equivalents of time would be required in just a 100-bed home.

Clause 76(1)(d) sets out that each home must provide any revisions to the information package to any person who has received the original package. This will require regular updates as well as a system to track who has received the original information package and subsequently received all of the revised packages. Without documenting this, there is no way for the inspector to confirm compliance.

As well, each non-compliance cited by an inspector requires a written plan of correction from the home that is then approved by the inspector for implementation. Since the majority of the existing long-term-care program standards are process standards, setting out what and sometimes how care, dietary service, housekeeping etc. is to be delivered is a requirement. Returning to compliance is not just about providing better care; it's about the homes revising their existing policies and procedures, protocols and guidelines to meet the compliance plan so that the documentation will be in order the next time an inspector arrives unannounced at the home. Bill 140 makes compliance and reporting an absolute and does not give compliance advisers the ability to be reasonable in their interpretation. Therefore, one can only assume from this that it will drive more emphasis on providing documented proof when a facility, for example, is in non-compliance.

**1020**

Lastly, I'd like to touch upon the licensing scheme in the new legislation and lack of capital renewal commitment. The importance of clarifying this issue further



cannot be overemphasized as the current language in Bill 140 leaves a large degree of uncertainty for the renewal of licensing for B and C homes. Also, in the first round of development in Ontario, capital funding was announced and provided to promote the development of A-standard homes and to rebuild D homes. This legislation does not provide this certainty and in fact places more stress on the system in terms of financing of long-term-care homes and on families, residents and communities, wondering whether licences will be renewed. Residents and their families who reside in B and C homes deserve the same consideration and commitment that was given to other communities when the new long-term-care beds were built to the new design standards. There is no commitment to funding in the current legislation. Our families and residents deserve access to the same physical comforts as the government is helping to provide residents in new and recently rebuilt homes.

I encourage you to consider the presentation to this committee by the Ontario Long Term Care Association in the area of capital renewal and fixed-term licensing. Our association, I believe, has outlined reasonable solutions to these issues.

I'd like to thank this committee for the opportunity to speak this morning on this important piece of legislation that is going to form the foundation by which long-term-care services and care will be provided in Ontario for years to come.

I am confident and hopeful that the presentations you've heard in this community and will hear later on today and others across the province will not fall on deaf ears and that this process will only serve to improve Bill 140. I urge you to consider this submission.

**The Acting Chair (Mr. Jeff Leal):** Thanks very much, Mr. Clement. We have about two minutes remaining. On this rotation, I start with the parliamentary assistant.

**Ms. Smith:** We have heard very similar presentations and I have a number of issues with some of the things you said today, but I'll only focus in on a couple.

The OLTC has put out the number of 2.5 hours per day of care. In fact, the government has said that its calculation is 2.86. Could you tell me what the OLTC includes in its 2.5-hour calculation?

**Mr. Clement:** I can't speak for the OLTC in terms of that calculation. My assumption would be, in terms of the 2.5, Ms. Smith, that it would include nursing care. That's my understanding.

**Ms. Smith:** How would you define "nursing care"?

**Mr. Clement:** My understanding in terms of how it's delineated is that it includes hands-on care as well as director of care, assistant director of care support and nursing administration support. The government as well as OLTC collect that type of information, and my understanding is that those types of calculations are included in the 2.5.

**Ms. Smith:** Right. You pointed out, on the documentation front, some kind of extreme examples. Can you point to me in the legislation where the homes are re-

quired to print off and circulate on a daily basis the communication on zero tolerance or where a home is actually required to document—I don't know how you put it—every hour, I think, the restraint of a resident in a home? Can you point that section out to me?

**Mr. Clement:** I don't have the legislation in front of me, Ms. Smith, but I can tell you that the legislation is absolute in terms of how it's presented. My experience in long-term care has been, as I mentioned, 17 years, not just as an administrator but in different areas. I am familiar with the process that facilities must go through to meet compliance. Certainly, with this particular piece of legislation, it doesn't promote any leeway in terms of our ability to actually show compliance advisers, for example, our need to be in compliance. So ultimately we are placed in the position where it's process in nature. We do have to prove to compliance advisers quite frequently—

**The Acting Chair:** Thanks very much. I want to give Mr. Ouellette and Ms. Martel an opportunity. Mr. Ouellette, please.

**Mr. Ouellette:** Thank you for your presentation. I appreciate the 17 years' experience that you have directly in this field.

My question is going to be quite short. What do you feel the direct impact is going to be with the wording of "shall"? How do you think that's going to impact the sector that you work in?

**Mr. Clement:** As I've mentioned, over the years I've had an opportunity, Mr. Ouellette, to see layoffs in long-term care. I've seen the process in the system that we've worked in over the past 17 years.

**Mr. Ouellette:** Do you expect that to take place now?

**Mr. Clement:** Quite frankly, the process in which we operate currently, we could very well see layoffs in the long-term-care sector as we move forward into the spring. I guess my point is that the government has to commit to funding because of the requirements that have been set out by the legislation. I recognize that there have been some improvements in the funding, but the reality is that I've lived through layoffs; I've lived through having to address issues with family members and residents in that regard. It's not a good situation because we're all in this sector, in long-term care, because we want to provide the best possible care to our residents and to our family members. I believe the government should be committing to the funding because they are committing to the standards. All we're saying is that we want to commit to those standards too, but put the resources on paper as well.

**The Acting Chair:** Ms. Martel, please.

**Ms. Martel:** Thank you for your presentation today. Ms. Smith asked you to point to the section in the legislation that would have you handing out information to people who come into the home. Let me help you out. In section 75, it says:

"Every licensee of a long-term-care home shall ensure that persons who perform work at the home, but who are not mentioned in subsection 74(1), are provided with

information in writing dealing with the following before they commence performing work:

- "1. The ... bill of rights.
- "2. The long-term-care home's policy to promote zero tolerance of abuse....
- "3. The duty under section 22 to make mandatory reports.
- "4. Fire prevention and safety.
- "5. Emergency and evacuation procedures.
- "6. Any other areas provided for in the regulations."

What's interesting is, if you look at section 74, that refers to people who provide hands-on care. So that's essentially staff. The question is, is someone who comes in to fix an elevator, who doesn't provide hands-on care, a person you have to give all this information to? Is someone who comes in from Bell to fix somebody's phone someone you have to give all this information to? If you have someone doing some repair work, contract work, is that someone you have to give all this information to? If you have people putting cable in the home for a particular resident, is that someone? They're not providing direct hands-on care.

So frankly, you are right. Under section 75, anybody who performs work, who is not a staff person, has to get all this information before they commence work. I don't see how your home or any other home is going to be able to cope with that. What do you think?

**Mr. Clement:** I agree with you, Ms. Martel. As I mentioned, I don't have the legislation in front of me, and I appreciate you quoting that. Again, the legislation is absolute, and I've lived it the past 17 years. As you pointed out, we will have to provide that information. So I believe there are some issues around documentation that are quite evident in the legislation. It's clear, as you pointed out, that that's going to be onerous and it will take away from the hands-on care that we would be required by this legislation to provide. I appreciate you pointing that out.

**The Acting Chair:** Thank you very much for your presentation, sir.

#### SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0N

**The Acting Chair:** I now call on John Van Beek of the Service Employees International Union, Local 1. Good morning, sir. You have 15 minutes, and any time left over will be reserved for questions.

**Mr. John Van Beek:** Thank you very much. I'm pinch-hitting for Cathy Carroll, our secretary-treasurer, who couldn't make it today.

I just want to thank the Chair and the members of the committee for allowing us to make a presentation again. Last Tuesday, Sharleen Stewart, our president, made a plea for 3.5 hours of care. In our brief, in the first half of that, you will notice that all of the Western world is setting a standard for care. The only place in the Western world where a care standard doesn't exist now is actually Ontario.

1030

Last Tuesday, the parliamentary assistant put out a number of 2.86 hours of care that the government claims each resident in the province is getting. I can't speak for the non-profit homes, I can't speak for the municipally run homes for the aged, but I can speak for the surveys that we have conducted in the private nursing home industry, of which we are the largest union, and there is absolutely no way, in terms of what the nursing care envelope presents or allows, that the care is 2.86 hours per resident per day.

My question to this committee, if I may—I think somebody's got to push this government, because the parliamentary assistant has been asking the question, "What do you think should be included in the 3.5 hours of care?" I want to know their methodology in terms of how they came up with the 2.86 hours of care. I think it's somewhat a deflection; it's somewhat spin. She threw out that number when we were in her riding in North Bay last fall, prior to the introduction of the bill. I think somehow the government is running scared in terms of being accountable to the people of Ontario. They made promises in the last campaign and haven't fulfilled any of them.

In any event, what I want to do today is the last part of our presentation, which is some amendments that we think are important that we didn't get to last Tuesday.

Let me start you off at page 26, the issue of residents' rights. There's a clear definition of abuse; in the act, it's defined as "physical, sexual, emotional, verbal or financial...." Nowhere in this bill is there a definition for "neglect of care." I think anywhere that abuse is mentioned, the definition should be extended to be defined also as neglect of care. It's something that staff don't have control over. The claim is that staff can now set up or help establish care plans and make decisions: No, they can't. They can only make decisions in terms of the financial resources that the home has or under the orders of the administration of that act.

I think one has to take a very serious look at abuse. Abuse clearly is a fist in the mouth, but abuse also is having a resident sit in a wet diaper until it's 80% wet. Abuse also is the fact that you can't help some resident with their toileting because two other bells are being rung. What happens if that resident falls off the toilet while the caregiver is attending to two other care bells? Is that abuse? And where does the abuse fall? It falls on the caregiver, right? A neglect of duty, I would think, because she couldn't attend to the needs of the person that she was toileting. So we suggest taking a serious look at what the definition of "abuse" is.

Also, just moving along in the presentation, one has to appoint an ombudsman. There is absolutely no choice. I think the American experience in terms of some of their ombudsmen spokespeople for residential care has worked tremendously well. It's clear in terms of their experience that the thing an ombudsman is most concerned about and that they get the most complaints about is, in essence, lack of care.



I don't think restraints have been addressed by very many people here. I think the issue of restraints in the act is good. The problem is with the chemical restraints. I have a suspicion that more and more chemical restraints are being used, simply in terms of taking a look at the number of drugs that are now being used in the nursing home sector. If you take a look at 2002-03 to 2005-06, drug costs have increased by about 70% over four years. I can't help but think that a lot of this is because more residents are being forced into a comatose state. I understand drugs have gone up and I understand that the population of nursing homes has gone up, but it doesn't account for the 70% total increase in drugs over that period.

Page 28: care and services. There is a provision for 24-hour RN care in the act—it's also under regulation now, in subsection 7(3)—but there's no provision for the number of RPN hours, PSW hours or health care aide hours. Clearly, what we demonstrated last Tuesday in our presentation was that in American jurisdictions there are ratios for an RN provision—for an LPN position, as they call RPNs in the United States—and also for personal support workers. The coroner's jury that looked at the Casa Verde deaths recommended 0.59 RN hours of care per day and 3.06 hours per resident per day for overall nursing and personal care. If you can have a standard for RNs, you can have a standard for the rest of the nursing staff.

Complaints procedure: We're not sure how this is going to work. Now you have a 1-800 number; you don't have an ombudsman. But does subsection 21(2), in terms of complaints being reported to the licensee, eliminate the 1-800 number? It may well.

Whistle-blowing protection: Section 24 is an excellent provision; I think the legislation, really, is limiting in terms of enforcement. It's going to be terribly difficult to encourage the reporting of abuse, particularly when abuse may be difficult to ascertain in terms of a legal context and when abuse really is a one-on-one situation, for which it is very difficult to obtain witnesses.

Staffing: section 72. We recommend that you amend that section to read, "That in order to provide a stable and consistent workforce and to improve the continuity of care to residents, every licensee of a long-term-care home shall ensure there is a staffing ratio of not less than 70% full time to 30% part time." That gives some continuity of care to the residents and eliminates, to some degree, the agency staff and that sort of thing. As a matter of fact, we would recommend no agency staff whatsoever. Then, of course, you add to that section that nursing care shall not fall below 3.5 hours of care per resident per day.

Page 31: training. We strongly believe in the issue that staff need to be better trained in terms of the kinds of illnesses and cognitive impairments that exist in nursing homes today.

The least we can do is elevate the certification level of a PSW. Again, the coroner's jury recommended that health care aides and PSWs have a governing body and that training in psychogeriatric aggressive behaviours should be implemented.

Quality management: Here's where it gets sticky, I think, between the for-profits and the non-profits. There is no enhancement in this act in terms of promoting the non-profit sector. Clearly, if they're going to compete with the large corporations that exist in our industry today, I think it behooves the government to provide some kind of training for boards of directors, particularly in terms of what their responsibilities are.

Funding is a major issue. We've heard from all kinds of long-term-care presentations over the course of the last week in terms of how the industry is underfunded, and we would agree. The problem is that all they're calling for is public money to enhance facilities, which will indeed enhance their bottom line in terms of the value of their property. I haven't heard them talk very much about care at all.

1040

When you take a look at Extendicare, which just the day after the federal legislation on income trusts turned itself into an income trust, when you take a look at some of the examples we provide in the brief, when you take a look at Macquarie Power corporation, which runs hydro-electric projects along with nursing homes and is basically an international finance bank, when you look at all of these kinds of people—residence income trusts, REITs—in the industry, what they're interested in is making a profit for their shareholders, and they're really interested in not paying tax at all. It's my money, it's your money and the Ontario taxpayers' money that's going to that. I'll give you some examples and, to be fair, not all of their money is made in Ontario. But the fact is that there's severe leakage in terms of Ontario taxpayer money going to for-profit as opposed to direct resident care.

We really do suggest that there must be a provision in this act that encourages the non-profit sector. I think that only in terms of issuing further licences, only where there is not a legitimate non-profit operator in a specific geographic area, should one consider a private operator's ability to bid on the licence in that area.

A number of other issues throughout the act: I think clearly, in terms of penalties, we need a very strong commitment from this committee that we won't, and this government won't, tolerate the kinds of abuses that happened in terms of Royal Crest Lifecare, where the Martino brothers basically ripped off millions and millions of dollars from Ontario taxpayers, didn't provide care, and the ministry never stepped in. We were able to resolve those issues as a union. Nevertheless, it was a big blow to the Ontario taxpayer. Those kinds of people should not exist in our nursing home industry in Ontario. We suggest that the fines must be very heavy in terms of for-profit corporations and their corporate directors. If you'll notice, there have to be criminal checks on the staff and everything else, but I don't notice anything in this legislation where there are criminal background checks on the directors of corporations that run the Extendicare, the Macquarie Power retirement residence REITs and that sort of thing.

Thanks. That's our presentation. I hope you'll have a serious look at our recommendations.

**The Vice-Chair:** Thank you very much for your presentation. I believe there's no time left for questions.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, AREA 6

**The Vice-Chair:** We'll move to the next presentation, which will be by the Canadian Union of Public Employees, Area 6. Welcome again, manifold talent. You can start whenever you're ready.

**Ms. Denise Lavoie:** Good morning. I would like to thank the committee for allowing me to speak at this hearing on a subject that is so near and dear to my heart. My name is Denise Lavoie. I have been working in a long-term-care institution, York Extendicare Sudbury, for the last 27 years as a health care aide. I am also the vice-president of CUPE 1182 and currently hold the position of Area 6 representative on the CUPE Ontario health care workers coordinating committee.

A minimum standard of 3.5 hours of care is essential to the well-being of those we are entrusted to care for. Currently there are simply not enough hands to care for the residents' daily needs with the dignity and respect they deserve. I'm not saying that they are not getting excellent care; they are, within the confines of the time allotted for tasks. And that is where the problem lies.

Because we have been task-oriented, the human factor has been minimized. Our seniors have all been hard-working individuals, giving us what we have today and making our future possible. Is it now fair to put them on the sidelines and make them wait daily for assistance with such simple tasks as eating or going to the wash-room? I personally feel that we do not treat our seniors the way we should. Let's not forget that we may all be in the same position; we cannot guarantee or predict our physical or mental well-being as we age.

The current funding system is inadequate and the current legislation does not have minimum staffing levels. CMI, or case mix index, is a snapshot of a resident at a particular time based on documentation, and documentation only. There is no human factor attached to this system. We, the long-term-care workers, often are the family of those we care for; after all, we are the ones they see the most. We form bonds with our residents and families; after all, they trust us to care and protect their spouses, mothers, fathers, siblings and sometimes their children. Those without families are especially vulnerable and in need of extra care. We are usually there to see to the end of their life. We want it to be dignified and pain-free. And, most importantly, no one should die alone; there is nothing sadder. We go to great lengths to know someone was there with them when they passed. We take great lengths to make sure that this does not happen. We have staff who give up their breaks and come in on their own time to ensure that they are not alone. We are affected by a resident's passing. They do become part of our lives and hearts. I think this is why so many of us stay regardless of the hard work. We are their advocates.

In a 24-hour period, our staffing level, when we're fully staffed by RNs, RPNs and health care aides, is at 2.3 hours of care per resident per day. Those 2.3 hours of care are from all the nursing disciplines stated above. Looking at the normal staffing levels for a health care aide, we have 96 minutes to provide the basic necessities of life in a 24-hour period per resident. They totally depend on us for every single need physically, emotionally and socially. This would include the serving of and assistance with three meals; three nourishment passes; assistance with the toilet or brief changes; baths, which the MOH has stated should be offered twice a week—shameful; how often do you shower or bathe?—assistance with ambulating, lying down, preparing for the day and preparing for bed; and assistance with repositioning and exercise, to name a few. It is not only a challenge but often an impossible task that leaves us drained both physically and emotionally.

On a normal day shift we have anywhere from eight to 12 residents to prepare for breakfast in one and a half hours. This equates to seven and a half minutes to 11 minutes per person. Many of these individuals require extensive assistance. Residents are being admitted with more complex care needs than in the past. This is in part due to the push to keep people in the community longer. So when they come to us, they need more help than in past years. Several residents are confused and have some form of dementia and require extra time to prevent agitation and aggression.

In addition to looking after the residents' immediate needs, we are expected to attend MOH-required in-services, facility in-services and education all within our regular shifts, and we are expected to care for the residents' necessities of life. Funding for staffing levels relies on daily documentation, which can take up 30 minutes or more per shift depending on the behaviour charting needed on any given day. This again cuts into the actual hands-on care time given to the residents.

The issue of violence in the workplace is something that is commonplace. In the instance of those with Alzheimer's or dementia, we are forgiving and understanding. After being in the industry so long, we tend to normalize or accept as part of the job being scratched, pinched or struck by the frail, confused elderly. I know it isn't right, but it does happen. We cannot, however, condone or accept some of the behaviours that are becoming the norm in many institutions. In the last few years, the demographics in nursing homes have changed. We are having to admit younger people with mental disorders, dementia, addictions and resulting behaviours, acquired brain injuries and other disabilities. We also have a percentage of the developmentally challenged residents who are aging and need specialized care. We do not have the facilities to deal with these residents. Previously, we could depend on psychiatric hospitals to house these residents, but they are being closed. These people have the right to be cared for as well or they will be on the streets trying to fend for themselves or end up in the court systems. We do not use physical restraints in our



facility, regardless of the behaviour exhibited. It becomes our job to monitor their actions. We have to institute a "code white" in our home to alert staff that assistance is needed until an aggressive or violent resident calms down or the police arrive to assist in dealing with the situation.

**1050**

The elderly—confused or aware—should not be exposed to this risk. Special training and expert units are needed to protect the rights of others, and by this I do not only mean the staff. It is also our duty at this time to ensure the safety of the elderly in our care and keep them out of harm's way. We have to be the eyes and ears for those who, in their confusion, cannot remove themselves from a potentially dangerous situation or who may potentially cause the situation to escalate. Sometimes the confused resident is the trigger for an episode. Specialized units would help a great deal in creating a safe and secure environment for our seniors.

As for the safety of the staff, as recently as last Thursday a staff member was punched in the jaw by a resident who falls within this category.

As of the latest budget, Public Interest Alberta and the Capital Health Authority report that funding is at 3.6 hours in that province. The Liberal Party of New Brunswick recently won an election with a pledge to phase in a minimum standard of 3.5 hours by 2008. Nova Scotia is increasing their previous 2.25 hours to 3.25 hours. Saskatchewan was at 3.1 hours in 2001, as reported by PricewaterhouseCoopers.

There is only one way to ensure that the quality of life for seniors is upheld, and that is to make certain that our residents receive a minimum of 3.5 or more hours of care each day, and in doing so, to provide adequate funding for required front-line staffing. Residents' care suffers because there is not enough staff in many homes and the number of hours allotted to care is simply not enough.

Our province is supposed to be the leading province in this great country of ours, yet it will not meet the needs of our aged in their time of need. I simply cannot understand this reasoning. Why is it so difficult to agree to treat our senior Ontarians with respect and dignity?

I would also like to add a little blurb here. I overheard one of my co-workers state, "We do not have enough time and hands to take care of the living. How are we supposed to find the time to care for the dying?"

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left; we can divide it equally among the three parties. I guess you're ready for questions. We'll start with Ms. Martel; two minutes.

**Ms. Martel:** Thank you very much for your presentation. I want to focus on page 3, where you say that specialized units would help to create a safe and secure environment for all our seniors. This was with respect to residents with violent behaviours.

As a result of the Casa Verde inquest—it was an inquest into the death of two residents at the hands of another resident in a long-term-care home—one of the 85 recommendations that was made was that individuals

who exhibit or who are prone to aggression be placed in specialized facilities or long-term-care facilities with specialty units, and further, that if the decision is made to place these individuals in a long-term-care home, then the Ministry of Health "must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self and others." Unfortunately, the ministry's response has been that they are only considering these recommendations.

I think that more and more homes are having residents come into them who are violent, who are prone to aggressive behaviour, and very little is being done to respond to that. What do you think about that recommendation, and can you give us any other idea of what's happening in your own home with respect to code whites, which clearly point out a need to start to deal with this situation?

**Ms. Lavoie:** We definitely need a place for these people to go, and I don't think a nursing home is the place for them. I think we do need specialized places for them to go to. They shouldn't be integrated with the frail and elderly. They should have a place of their own.

**Ms. Martel:** How many times is there a code white?

**Ms. Lavoie:** Lately, almost on a daily basis.

**Ms. Martel:** So a code white is to alert staff that assistance is needed because you've got an aggressive or violent resident or that police are arriving?

**Ms. Lavoie:** Yes. That has happened quite a few times.

**Ms. Martel:** How many times did the police arrive?

**Ms. Lavoie:** She works on that unit, so I'll let Valerie answer that.

**The Vice-Chair:** Please state your name before you start.

**Ms. Valerie Trudeau:** Valerie Trudeau. We have just instituted the code white in the last month. It has been called once over the PA since I've been there, but we do have instances of a few residents who require one-on-one supervision. The employer has applied to the ministry for specialized funding in order to have the one-on-one supervision. Unfortunately, we don't always have the staff to do that.

**The Vice-Chair:** Thank you very much. Mr. Leal.

**Mr. Leal:** Thank you for your detailed presentation. I want to ask a question concerning the 3.5 hours. Earlier this morning we heard from Ms. Graham, who works in Kirkland Lake, indicating that from her perspective, the component parts of the 3.5 hours should be RPN, PSW and a portion for administration. I'd like to hear your thoughts on what component parts should be in those 3.5 hours.

**Ms. Lavoie:** I think it should mainly be on the PSWs and health care aides because we are the front-line workers; we are the ones providing direct care, and for the RPNs, because in our facility on the afternoon and night shift, one RPN takes care of 58 residents for their

medical needs, dressings, emergencies that arise; and it's just simply not enough. These are supposed to be their golden years where they're supposed to be well taken care of. You shouldn't have to rush a 96-year-old person, and you shouldn't have to drag them out of bed. They're supposed to be retired.

**Mr. Leal:** So from your view and your experience as a front-line worker, you wouldn't have an administrative component in that 3.5 hours?

**Ms. Lavoie:** I don't think so. The RNs do play an important role in a nursing home, of course they do, but we are the ones that do the direct care.

**Mr. Leal:** If I could just ask one further question, if I have time, Mr. Chair.

**The Vice-Chair:** Yes, go ahead.

**Mr. Leal:** I just want to follow up. I was interested, and I'm not sure I heard it: Your code white approach to dealing with a resident who exhibits aggressive behaviour—I was wondering how many times police were actually involved to calm or take appropriate action from that angle to deal with an aggressive—

**Ms. Lavoie:** To my knowledge—I've been at the home when this happened—at least three times in the last month.

**Mr. Leal:** Does the Sudbury police force have special training for their officers who might be involved in a response to a code white situation?

**Ms. Lavoie:** I really don't know.

**The Vice-Chair:** Thank you very much. Mr. Ouellette.

**Mr. Ouellette:** Thank you very much for your presentation. I have a sister who works as a PSW, and when I mentioned the abuse part of the legislation, she was so thankful that something was coming forward to deal with the actual workers in the field. How do you think the restraint policy is going to affect that relationship with the workers and how they are going to be dealt with by individuals who are, shall we say, less restrained?

**Ms. Lavoie:** I don't believe in restraints unless there is no other way to do it. I just don't think that the potentially violent people should be integrated with the elderly.

**Mr. Ouellette:** So how do you take care of them or what steps do you move forward with to address this issue?

**Ms. Lavoie:** Your approach does mean a lot, up to a point. We don't have the time to take the time to be gentle and try to approach slowly. We don't have the time. If we had more staffing, maybe the aggressiveness level would be lower because we would have the time to deal with this properly.

**Mr. Ouellette:** So the end result would be what in this particular case as it moves forward as legislation the way it's laid out? What do you expect to see within the facilities then?

**Ms. Lavoie:** I would like to see the minimum standards up to at least 3.5 so that we, like I say, can deal with these situations in a more timely manner without

having to rush anybody, because when you rush people, you do escalate the potential for violence.

**Mr. Ouellette:** I would imagine that in situations like that where they're not separated into other facilities, that the time—for example, 10 people at 3.5 would be 35 hours effectively—those individuals would demand a lot more time and that would take away from the time the other individuals should be receiving.

**Mr. Brian Blakeley:** Brian Blakeley with CUPE research. One thing that we need to be careful about is that these individuals being accommodated in long-term-care facilities is not new; it has been going on for a long time. I think you've heard in this presentation and in previous presentations that the response to it needs to be assessment of the individuals and staffing to meet the needs of each individual in the facility. So, as in the school boards with educational assistants, there are individuals in school systems who require one-on-one staffing; there are individuals in school systems who require one-on-20 staffing. It's the funding issue and the 3.5 and the assessment of needs that we think need to be addressed more clearly.

**The Vice-Chair:** Thank you very much for your presentation.

1100

#### TEMISKAMING LODGE

**The Vice-Chair:** Next will be Temiskaming Lodge. Welcome.

**Ms. Elizabeth Brownlee:** Thank you. May I go ahead?

**The Vice-Chair:** Yes.

**Ms. Brownlee:** Members of the standing committee on social policy, fellow speakers and guests, good morning. My name is Elizabeth Brownlee. I am the administrator of Temiskaming Lodge in Haileybury and currently an acting care services coordinator with our parent company, Jarlette Health Services. I have worked in long-term care for over 15 years of my nursing career and have also held the positions of charge nurse and director of resident care. I am involved with others in attempting to address the health care needs in our community, including LHINs and the Dementia Network in the district of Temiskaming.

Another perspective that I bring to this table is that of being a family member of a long-term-care resident for the past year. I must tell you that this experience provides much clarity to my official role of administrator. It has also provided me with invaluable insight into what it is like for our residents and family members to navigate and function within the context of our long-term-care system.

Temiskaming Lodge is a 25-year-old B facility which is home to 80 special people who require and deserve the best-quality care that we are able to provide. Temiskaming Lodge is employer to 83 caring and committed team members who will tell you that they proudly provide that quality care.



Today I am before you to explain how Bill 140, as it stands, will affect our residents and their home. I hope that the few minutes I have with you will bring you to their bedside and their reality, because, as always, this is about the residents whom we collectively serve.

First, please allow me to set the stage by attempting to paint a picture of the day-to-day realities of life in our home.

Repeatedly, the key issue for our residents and their families is that there is a need for increased staffing levels or more hands available to provide efficient and timely care. This issue is not new, and we are all acutely aware of how care levels in Ontario are below those of many other Canadian provinces.

In our home, and I am positive that I can say "in all our homes," we continually monitor that call bells do not ring for more than a few minutes. However, when staff available are already occupied providing personal care to other residents who may require two or more staff to meet their needs, it is difficult, if not impossible, to attend quickly. Residents and family members will tell you that the staff members in our homes are always on the run. They see their care providers called away from one task to attend to the needs of another time after time. This leaves some residents hesitant to ask for the help that they need and simply does not allow for much of the non-care-related interaction that they crave and deserve. The outcome is sometimes injury from attempted self-transfers, as well as loneliness. This price is too high.

It is upsetting for families to see unmade beds in their loved ones' rooms in the early afternoon, and frustrating for staff to have to explain that the trade-off was that everyone was provided with toileting and changing after lunch—such a basic need. Increased levels of care would not only help us to take better care of our residents but they would help family members to feel confident and reinforce that their loved ones are receiving the care that they want them to have.

This rush and the feeling that there is never enough time is very difficult for our workers, who went into health care to make a difference. The current paucity of health human resources in Ontario and the difficulty recruiting to long-term care means that we not only have to retain our workers but we have to allow their jobs to be rewarding. If we can improve this sense of job satisfaction, we will be able to increase the numbers of personal support workers and nurses, particularly those who want to work in long-term care.

A compounding issue related to unacceptable levels of care is that of safety. When our care providers feel rushed, they are more prone to working in a hurried and unsafe manner, increasing the potential of workplace injuries. Recent funding initiatives to increase the number of mechanical lifts in our homes indicate government's responsiveness to the issue of workplace injuries. I ask you to consider the negative impact on safety for care providers who work under constant pressure to hurry.

There are several aspects of Bill 140 that have the potential to impact on resident care and cause us concern.

The concerns that I would like to highlight include increased emphasis on paperwork, increased regulation around internal processes, and issues impacted by licensing.

Paperwork is a concern for us as we have had huge increases in the documentation that we are required to maintain. An example would be the numerous detailed assessments required within hours of admission, such as continence, head-to-toe and pain assessments. While some of this paperwork is important to resident care, it does take us away from the residents and family members who need our interaction and support.

Ensuring that every person who does work in our home has received a copy of our abuse policy is not realistic. Meeting this requirement would mean that an emergency worker, such as an ambulance attendant, would be obligated to have a copy of our abuse policy prior to providing care to a resident. It would increase the time that we spend making copies of our abuse policy and ensuring that we have created a paper trail as evidence. We already spend much time and energy creating awareness and educating about abuse, as we appreciate that the safety and security of our residents is paramount.

Another issue with paperwork is about the number of official documents that we will be required to post on our walls. In our home, we strive to provide a home-like setting that is warm and inviting. Posting a plethora of documents will be a challenge. Smaller homes like ours will have difficulty finding wall space that doesn't compromise the feeling of home that we have worked so hard to achieve.

Currently, we have a policy of "least restraint" in our home, and if we do have a restraint, hourly checks and documentation are required, as well as regular, detailed assessments. Bill 140 proposes to redefine restraint to include the magnetic locks on our doors as perimeter restraints to residents who are unable to manage the code. This would require us to complete detailed assessments and hourly documentation on approximately 60 residents each day. The result would be hours and hours of time spent checking on residents and documenting restraints—time that we simply do not have.

Paperwork is vital to what we do, and our residents do benefit from this evidence of our accountability. However, it is important to keep the amount of time and energy spent on paperwork relative to the time spent providing care in perspective. We must also remain cognizant of keeping our homes looking like homes.

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It is disappointing that Bill 140 does not provide assurance of assistance with capital renewal for our remaining B and C homes. We, along with our residents and their families, have looked forward to having the same amenities as those who now reside in newer homes: more privacy, smaller home areas, smaller dining rooms etc.

Temiskaming Lodge is a B facility and over half of our residents are in four-bed or ward rooms. This frequently poses difficulties with not only compatibility

between personalities but also with providing for individual needs. Residents with no cognitive impairment find themselves sharing their bedroom with other residents who are very confused. These confused residents unintentionally invade the personal space of others and often have rummaging behaviours. Altercations between residents can be verbally or physically aggressive and require staff intervention. Residents find themselves with roommates who are restless at night or require frequent care from staff, which causes noise and disrupts their sleep. New facilities no longer have these four-bed wards, which helps to limit issues and promotes feelings of safety and security for our residents—safety and security, which are so important to the elderly.

The other disadvantage of older homes is that we do not have smaller dining rooms as are now the standard. Instead of a maximum of 32, we have 80 residents dining together in one large room. There is often noise and disruption at meal times and it is difficult to accommodate increasing amounts of equipment. Some residents have physical or emotional needs that result in upsetting behaviours, while some residents have negative reactions to the busyness of this setting. This makes the provision of a positive dining experience quite a challenge for staff.

Government has not rendered a commitment with Bill 140 that our home would be eligible for assistance with capital renewal as there has been for new homes or those that required rebuilding to meet current standards. We remain hopeful that you will ensure that our residents in older facilities have access to the same amenities as those in new and rebuilt homes. This challenge is particularly relevant for smaller northern and/or rural homes, and we ask you to show that you have not forgotten us by committing to a capital renewal program.

The issues around licensing affect all homes, particularly homes in the north such as ours. While operators have attempted to manage the fears of residents and staff in understanding what the legislation says, it is impossible to be reassured about the future with the existing wording in the bill. This wording leaves them wondering if the government will decide to close their home; take away some of their beds; ask them to rebuild or renovate without the capital renewal program or certainty over their operating licences required to make this happen; or, indeed, do nothing at all and leave us still struggling to address the issues I just outlined over the next 10 years or more.

This is too much uncertainty in the face of our current challenges. It provides us with no comfort that either the quantity or quality of long-term-care services will be there in our community to meet the increasing need.

The owner of our home needs more reassurance and more information to be able to make sound business plans for the future of Temiskaming Lodge. Our owner takes pride in running high-quality homes and deserves this commitment to be recognized.

Members of the standing committee, I thank you for the opportunity to share with you this morning the realities of the residents and staff of Temiskaming Lodge.

As an experienced long-term-care manager and the granddaughter of a long-term-care resident, I hope that this committee will support the detailed amendments that the Ontario Long Term Care Association has submitted.

The mission of Jarlette Health Services is to "Make an Outstanding Difference in the Lives of Others." I hope that you embrace this opportunity as a committee to do the same.

**The Vice-Chair:** Thank you very much for your presentation.

#### LINDA EVES

**The Vice-Chair:** Next will be Linda Eves. Linda, to my knowledge, you're not representing Leisureworld Caregiving Centre, are you?

**Ms. Linda Eves:** I'm not presenting for Leisureworld, no.

**The Vice-Chair:** You're representing yourself.

**Ms. Eves:** Yes. Good morning to the committee and everyone present. Margaret Mather, who was to present with me today, was called away on a family emergency. She sends her apologies to the committee. If I may, I'll begin my presentation. Actually, it's our presentation, so you may hear "we" instead of "I."

We—Margaret Mather and myself—are both employed at Leisureworld Caregiving Centre in North Bay. We would like to state that we are not here today to represent Leisureworld, but to present our concerns on Bill 140 as both front-line health care workers and members of Service Employees International Union, Local 1.

Let me begin by saying that, in our humble opinion, Bill 140 does nothing for seniors in long-term-care facilities. Inadequate funding means less care can be given to each individual resident—care that each resident deserves in their golden years.

My colleague and I have been employed at Leisureworld in North Bay for a combined period of 38 years. Our residents have experienced favourable care, but the lack of sufficient staff on the floor means the level of care deteriorates. It cannot be overstated that certain residents require considerably more care than others. Currently, we have 148 residents in our home. The total amount of nursing and personal care, with HCA/PSW and RPN hours factored in, is approximately 1.89 hours per day. The Ontario Liberals committed to reinstating the 2.25-hour standard of care that was removed by the Harris government in 1996. This has not been done.

As front-line workers, we are the eyes and the ears of the long-term-care system. We see the need for more staffing so our residents can have the quality of care they deserve, as opposed to the rushed atmosphere present funding levels provide. In our home we have 57 residents on one floor, with five health care aides. Our shift begins at 6:30 a.m. From 9 to 11:30 a.m., one health care aide assists the bath person to do 10 baths, leaving four staff to answer bells, attend to personal needs, make beds, do morning nourishments etc.

Often, there are two or more call bells ringing at one time, and it is impossible to meet resident demands



immediately. The very ill and palliative care residents require more attention from staff. At meal time, one staff may be required to feed two residents, and after the meal the routine is reversed: helping people to bed, attending to their personal needs and charting, which, for the health care aides and PSWs, takes up to 45 minutes—time taken away from the resident.

The present funding formula, the case mix measure, CMM, which determines the case mix index, CMI, does not always reflect resident intervention or activities, due to a lack of time to complete a shift's charting.

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Unrecorded incidents will drive the CMI down, regardless of the changes in resident care or population. Now a new formula has emerged and the ministry claims the new RAI will be the basis of future improvements to the funding system. This would be wonderful; however, if the staff cannot complete the increased charting, then both the funding and the care will continue to suffer. Nothing will change.

Service Employees International Union, Local 1, states this will not be enough to maintain the level of care for each individual. Residents deserve a minimum standard of 3.5 hours per day of nursing and personal care. This must be implemented by the government in Bill 140.

For our members, Bill 140 is a seriously flawed piece of legislation, bordering on a tragedy in a province such as ours. It is a betrayal of the wishes and needs of our seniors and families who have members in these facilities.

Bill 140 outlines the residents' bill of rights, numbers 1, 3 and 4, as follows:

"1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity....

"3. Every resident has the right not to be neglected by the licensee or staff.

"4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs."

However, it falls short by not providing a set standard of care that will go a long way to ensuring that these rights, as outlined, can be met. Only the government can rectify the situation. And we respectfully request that this government heed the concerns of dedicated employees of the nursing homes, the residents and their families by incorporating a 3.5 hours per resident per day standard of care in Bill 140.

Thank you for the opportunity of appearing before the committee on social policy to share our concerns.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We can divide it among the three parties. We have, first, the parliamentary assistant.

**Ms. Smith:** Thanks from coming from the Bay.

**Ms. Eves:** You're welcome.

**Ms. Smith:** Nice to see you.

**Ms. Eves:** Nice to see you.

**Ms. Smith:** I was at Leisureworld not that long ago having a big dinner downstairs; it was great. I know the great work that you do there and what a good home it is.

I wanted to ask you about your calculation. In your presentation, you talk about the hours per day and you talk about your particular—I think that number, 1.89, is Leisureworld North Bay.

**Ms. Eves:** Yes, it is.

**Ms. Smith:** Who calculated that number?

**Ms. Eves:** I did, and it could very well be wrong.

**Ms. Smith:** Okay. We've done provincial numbers and our average is about 2.86.

**Ms. Eves:** My math skills are not great.

**Ms. Smith:** I was just wondering, how did you come up with that calculation? What did you include in that?

**Ms. Eves:** All the health care aide hours. We have three floors within our building; we call them cares 1, 2 and 3. The health care aides on each shift; it also included the bath people, which we have; RPNs. We have a float RPN and we also have a treatment RPN. The RN hours were not factored into that. Then I just divided it by the number of residents we have in the building, which is 148.

**Ms. Smith:** And you didn't include dietary aides or activity people?

**Ms. Eves:** No, I did not. It was strictly nursing.

**Ms. Smith:** In calculating the 3.5 that you're advocating for, that you'd like to see implemented, would you include the health care aides, the RPNs and the bath people?

**Ms. Eves:** Yes.

**Ms. Smith:** You wouldn't include the RNs or any other people who are involved in the care of the residents?

**Ms. Eves:** I think the RNs have a very important role within the nursing homes. They give us guidance; they certainly do the care plans.

**Ms. Smith:** So they are involved in the assessment of the residents.

**Ms. Eves:** Most definitely.

**Ms. Smith:** Do you call on your RNs when you have a problem?

**Ms. Eves:** Yes.

**Ms. Smith:** So they are involved in the care?

**Ms. Eves:** They're very supportive.

**Ms. Smith:** But you still wouldn't include them in the 3.5.

**Ms. Eves:** Well, I didn't with this.

**Ms. Smith:** But generally speaking—

**Ms. Eves:** No, I'm selfish, as I heard earlier. I think we need the direct hands-on care for the residents.

**Ms. Smith:** Okay. I really appreciate you coming. I'm glad that the weather wasn't too bad this morning.

**Ms. Eves:** Not too bad. North Bay was a little worse than here.

**The Vice-Chair:** Mr. Ouellette. Two minutes.

**Mr. Ouellette:** Thank you for your presentation. To continue on the 3.5, the more we hear about the details, I

find that setting a fixed number for individuals will be very complex to do. We have such complex and detailed requirements by individuals. I think some individuals may require more. You stated that some require two to do certain things and some would require less. The end result is that we would end up robbing Peter to pay Paul, so to speak, as took place, as other presenters have said, when the nursing envelope was used for various aspects.

Do you think that an in-depth assessment would be a far better way to determine individual needs, to move forward with ensuring the quality of care? What I think is going to happen is that if it were moved to 3.5, all of a sudden administration would be thrown in there. They would be doing the same thing and they would find ways to justify it, but the individual would be the one who ends up losing.

**Ms. Eves:** Wouldn't that be accountability on the part of the nursing home?

**Mr. Ouellette:** I would hope so.

**Ms. Eves:** If it is 3.5 hours, that they are accountable to the government for staffing 3.5 hours of hands-on care?

**Mr. Ouellette:** Right.

**Ms. Eves:** And that additional areas are not sort of hidden and thrown in? Am I understanding properly?

**Mr. Ouellette:** Exactly what you said about hands-on care: What is the definition of hands-on care and how do you break down the difference? Individual assessment, a far more in-depth assessment to determine the individual's care levels, would probably have a much greater impact.

**Ms. Eves:** As I mentioned earlier, the RAI has emerged, which is resident assessment instrument. I'm not really totally involved with that other than our initial charting, which we must do per shift, which does take considerable time, up to three quarters of an hour per staff, per shift, which is taken out of the resident time.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** I apologize for being out of the room, but I've had a chance to look at the brief and I wanted to ask you some questions. First of all, thank you for being here, because you've had to travel as well.

I guess regardless of what assessment you use, what the tool is, if you discover that residents need more care, then you have to fund the staff to provide that care. In the last election, the Liberals said that they would provide \$6,000 more for each resident for direct care, for enhanced care. So far, they've delivered on only \$2,000 of that, or about one third. So they've got a long way to go. My sense is that if they actually funded the \$6,000 per resident, we would be in a position to meet the needs of residents, no matter what tool we're using for assessment.

If you look in your home and describe some of what's going on, what kind of changes could you make directly to the residents you're trying to care for if you actually had more time and if there were actually more staff, to have the hands to meet the needs of those people you're trying to help?

**Ms. Eves:** I could see applying nail polish, doing hair—simple things. If residents are unable to afford the hairdresser in the facility, then we would have that extra time. A lot of our residents—or makeup. They wore lipstick. We don't have the time now to meet those needs that maybe they want.

Do we have time to sit and hug someone if they're crying and having a bad day, like we often have? Sometimes they just need a little extra hug, an assurance that everything will be fine and, "I can stay with you. I don't have to run away right away and answer that bell." Their needs have to be met too and it does become frustrating.

**Ms. Martel:** For you and for them.

**Ms. Eves:** For everyone.

**The Vice-Chair:** Thank you very much for your presentation.

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## SOCIÉTÉ ALZHEIMER SOCIETY SUDBURY-MANITOULIN

**The Vice-Chair:** We'll move to the next presentation, which would be by Société Alzheimer Society Sudbury-Manitoulin.

Welcome. You can start any time you are ready.

**Ms. Patricia Montpetit:** Mr. Chairman, members of the standing committee on social policy, thank you for this opportunity to discuss Bill 140. My name is Patricia Montpetit and I am the executive director of the Société Alzheimer Society Sudbury-Manitoulin. With me is Janet Bradley, the past president of our chapter's board of directors.

The Société Alzheimer Society Sudbury-Manitoulin was incorporated in 1985. Our mission is to alleviate the personal and social consequences of Alzheimer's disease and related dementias and to promote research. We strive to improve the quality of life for our clients, their families and caregivers through support services, education and advocacy.

One service of the Sudbury-Manitoulin chapter worth highlighting is our adult day program. Client activities happen in a homey setting under the supervision of professional staff who are equipped with the education and experience necessary to care for those with memory loss. However, the day program is but one of many services we provide, including in-home respite, a wandering person registry, supportive counselling, health teaching, support groups, a resource centre stocked with educational books and videos, newsletters and research funding. We also provide education and training regarding dementia care to staff members at long-term-care facilities, retirement homes and community agencies.

Four objectives unite these different programs. The first is to maintain the person with Alzheimer's disease and related dementias in the community for as long as possible. The second is to provide respite for the caregiver of the client. The third is to stimulate, protect and comfort the person with dementia. Fourth is to teach,



train and counsel Alzheimer caregivers, including front-line staff of long-term-care facilities.

Demographics indicate that there currently are 2,650 individuals with Alzheimer's disease or a related dementia in the Sudbury and Manitoulin districts. In the next 25 years, this number will rise to almost 5,000 individuals. Most of these people will spend the final years of their lives in a long-term-care home.

In 1998, the Société Alzheimer Society Sudbury-Manitoulin demonstrated its commitment to the importance of a continuum of geriatric services. In collaboration with Pioneer Manor, the city of Greater Sudbury's long-term-care facility, municipal and provincial political representatives and various community agencies and hospitals, the Alzheimer Society subscribed to the vision of a seniors' campus on the grounds of Pioneer Manor. What makes this seniors' campus so unique is its inclusion of a memory assessment network, applied research, redeveloped long-term-care beds and an expanded Alzheimer day centre. Future plans are for a supportive housing component and short-stay respite beds.

In 2002, our board of directors launched a capital campaign to raise \$2.1 million to build the new Alzheimer centre. Last year, we finally reached our goal and began construction to renovate 10,000 square feet of space in a vacated older section of Pioneer Manor. We moved into our lovely new centre last summer.

Having painted Sudbury's long-term care in broad strokes, I now turn to the finer points of Bill 140. There are several recommendations to Bill 140 that we believe, if implemented, will improve the proposed legislation and further protect the rights of long-term-care residents.

Section 27, "Minimizing of restraining": The inclusion in Bill 140 that each facility be required to have a policy designed to minimize the use of restraints is commendable. To ensure that the minimizing of restraining can be accomplished requires further staff training to use various programs that do minimize the need for restraints. Program possibilities include the Gentle Persuasive Approach and U-First, two programs based on the principle of person-centred care for dementia patients. In Sudbury and Manitoulin, specialized training is offered through the local Alzheimer Society chapter to the staff of all long-term-care facilities.

Subsection 74(6), "Additional training—direct care staff": Although we commend the bill's provision on training, an amendment should be included to incorporate management staff as well. Furthermore, it is imperative that front-line staff be granted paid time to undergo training without being simultaneously responsible for patient care. While the Alzheimer Society gladly provides advanced training to local long-term-care staff, our efforts are undermined by the 20-minute slots we are sporadically allotted. During these sessions, the staff member is distracted by her care commitments, with insufficient time given for proper training even under ideal conditions.

Subsection 24(1), "Whistle-blowing protection": While the whistle-blower section is particularly import-

ant, it is imperative that an amendment be made assuring that the whistle-blower is protected from retribution.

Section 35, "Office of the Long-Term Care Homes Resident and Family Adviser": The role of the resident and family adviser is not well defined and should be expanded on and clarified in the bill. The role of this office in relation to residents with Alzheimer disease and related dementias will be especially important in light of their often limited capacity for comprehension. In our opinion, this office should provide its annual report to the Legislature as well as to the Minister of Health and Long-Term Care.

Behavioural assessment units: We recommend that a small behavioural assessment unit be established in at least one long-term-care facility in each region, modelled on those already in operation in St. Catharines, Hamilton and Kitchener. Such units would do much to reduce the likelihood of severe aggressive behaviour.

We applaud the expansion of long-term-care facilities in Sudbury to include 96 additional beds. However, our most pressing concern remains an insufficient long-term-care capacity, especially in northern Ontario. In its absence, individuals occupy more costly acute-care hospital beds while awaiting admission to a long-term-care facility. Aside from the financial burden this imposes, we know that people with Alzheimer's disease handle change with greater difficulty than the normal population. To have them languishing in the hospital for long periods is counterproductive, not least because they will be forced to readjust again when finally admitted into long-term care. To combat this problem, we recommend that fast-tracking be introduced to expedite the transfer of hospital patients with dementia who are long-term-care applicants.

We also advise more short-stay beds for people with dementia, as well as more community-based home care, in-home respite and adult day programs in order to help keep people with dementia out of hospitals and long-term-care facilities for as long as possible.

Before concluding, Mr. Chairman, it cannot be emphasized enough that quality care demands adequate resources to enable the success of front-line workers. While Ontario may surpass other provinces in terms of policy progression, without the necessary funding, Ontario cannot translate its policies into practice.

Janet Bradley and I are prepared to answer any questions from the committee. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can divide it equally between the three parties. We'll start with Mr. Ouellette.

**Mr. Ouellette:** Thank you for your presentation. In part of it you mentioned the U-First program, as well as the Gentle Persuasive Approach and person-centred care. How is that achieved? I would expect that this would require a lot more time in order to do that.

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**Ms. Montpetit:** That always comes up in these training sessions. I think the standard answer is usually

that it doesn't have to take more time, because the result is that it decreases the number of incidents; therefore there is not as much time required to deal with all the aggressive incidents. However, I think that to initially implement, yes, it does require more time. I think that somebody from one of the CUPE presentations mentioned that they need more time in order to be able to have a gentle approach and not a hurried approach. The more hurried you are, certainly the resident picks up on it and it increases aggression. So, yes.

**The Vice-Chair:** Thank you, Ms. Martel.

**Ms. Martel:** Thank you for your presentation. I just want to say to you, Pat, that the work the society provides is excellent. My grandmother was a beneficiary, as you well know, at the adult day program and respite home care before she had to go to Pioneer Manor, and we were very grateful for that.

I just want to focus on subsection 74(6), where the government talks about the additional training for direct care staff and lists the additional training that those who are providing direct care to residents have to receive as a condition of continuing to have contact. All that is well and good, but as you point out on the last page, if you don't have the funding to do it, it's all going to be for naught. I think you made it very clear that you're already having trouble providing training because workers haven't been backfilled by other staff in order to receive the training, and I suspect that the 20-minute slot isn't as much as you'd like to provide either.

**Ms. Montpetit:** Definitely not.

**Ms. Martel:** So in a world where the government was providing the funding for training, what would you like to provide? What would be necessary, in your view?

**Ms. Montpetit:** Many of our sessions—for example, U-First is a full-day training session. If the staff right now are sent to that session, then they do have to have somebody replacing them on the floor. So I think there has to be a certain amount of money in each long-term-care facility's annual budget for backfill, for replacement of staff while they are not on the floor.

**The Vice-Chair:** Thank you very much. Parliamentary assistant.

**Ms. Smith:** Thank you for presenting today. I'm delighted to hear from the Alzheimer society. I was part of the Alzheimer's walk in North Bay on Saturday morning. It was a great event. We had lots of people out.

I'm glad that Ms. Martel raised subsection 74(6), because we do outline the types of training we'd like to see front-line workers receiving. Included in that are dementia care and behaviour management, as well as least restraints, and certainly part of that drafting was informed by the existence of U-First and PIECES. On my review of long-term care in 2004, I spent a lot of time visiting about 30 homes. We would ask if staff had received U-First and PIECES, and we heard a lot of comments such as that one staff had, but hadn't had the opportunity to train the trainers because of the backfill issue and the other staffing issues.

**Ms. Montpetit:** Very common.

**Ms. Smith:** Yes. So it is something we're aware of.

I'd just like to point out that in subsection 24(2) we do set out the defence against retribution against staff or retaliation, and in subsection (3) against residents. So when you were talking about whistle-blower protection, that is there in the legislation.

I also just want to congratulate you on the centre. I know that there was a fire, and I hope that everything is okay in your world and that you've been able to get back into your program.

**Ms. Montpetit:** Pretty much back to normal.

**Ms. Smith:** Excellent. Congratulations.

**The Vice-Chair:** Thank you very much for your presentation.

## ALGONQUIN NURSING HOME

**The Vice-Chair:** We'll move to the next presentation, which will be the Algonquin Nursing Home. Welcome. You can start whenever you're ready.

**Ms. Vala Monestime Belter:** Good morning. I'm Vala Monestime Belter, administrator, registered nurse and owner of the Algonquin Nursing Home in Mattawa. With me today is Janet McNabb, director of care. Thank you for letting us share our concerns about Bill 140 with you.

In addition to my role as owner and administrator of Algonquin Nursing Home, I have been a member of the Mattawa General Hospital board of directors, the province's e-health subcommittees, and have been on the CCAC's community advisory council as well as several provincial non-health-related bodies.

Janet is a registered nurse and director of care at our home. She has 30-plus years' experience in acute and long-term care throughout the province. She can speak as a town councillor, chair of Mattawa Community Living, about-to-be board member of our local health unit and, most importantly, as a family member of someone living in a long-term-care home—ours.

We bring this well-rounded perspective to our presentation today on behalf of our 73 residents, their families, our 75 employees and over 200 volunteers from almost every service or church group. We are representing their collective concerns over the implications of Bill 140 for the future of their home and the services it provides.

Let me begin by telling you a little about our home and its role in the small, beautiful and bilingual community of the Mattawa area. My father, the late Dr. Monestime, then mayor of Mattawa, mortgaged our family assets in 1976 to build a long-term-care home for the people of East Nipissing. My mom, Zena Monestime, worked as administrator of our home until her death two years ago. She was also a resident for two years, so I too can speak to you as a family member.

Our home is nationally accredited, provincially licensed and designated under the French Language Services Act. Many of our staff have family members who live in our home. It's a home that you would not



hesitate to live in yourself, and may I suggest as you deliberate and plan any revisions to this act that you selflessly consider your outcomes as applicable to you individually in the future.

Our home is now 30 years old. It's classified as a B home because in 1996 we again personally signed a \$1.3-million mortgage to enhance our home. We have a beautiful dining room, good resident living areas and a good staff room. We made this investment as a continuation of my father's original philosophy out of respect for the people we care for and those who provide that care.

These renovations did not in any way bring any financial return on investment. We recognized in 1996, as my father did when he originally built, that the people in our community are not wealthy. They are still loggers, farmers or seasonally employed. They did not and still do not have big company pensions. It's difficult for them to afford the additional costs of semi-private rooms and now, quite frankly, unfair for them to have to, when two people to a room is the basic accommodation standard in new and rebuilt homes.

The bottom line is that we still have four-bed ward rooms. Our residents pay the same fees as those in newer homes in Sudbury, Orillia or Ottawa where, at most, there are two residents to a room. Government is subsidizing this through the capital funding they are providing as part of the 20,000 new bed and 16,000 D-bed redevelopment programs. They will help fund the same for residents who will live in the 1,750 beds that are about to be built. Not so for the 73 residents of our home. They are part of the 35,000 residents throughout Ontario who get noticeably less for their money and, right now, are feeling forgotten.

With the uncertainty created by the provisions of Bill 140 and no commitment to a capital renewal program, Algonquin Nursing Home's residents know that this is their future, assuming the government decides we still have a future. For example, I have two mortgages coming due, one in two months and another in a year. My banker is already skittish. He called me after the government's meeting with the bankers a few months ago, and he was not reassured in the least.

We are obviously concerned over the potential implications of this uncertainty for our existing financing. Along with residents, families and staff, we are deeply disappointed that this is preventing us from moving forward with a planned major renovation project. We have the infrastructure in place and the overall plans developed and ready for submission to the ministry. I have now put these plans on hold. What bank would finance millions of dollars in renovations when I can't tell them with any degree of certainty how long the home will exist to be able to repay that financing? I think it's also fair to say that had we had the reassurance over our future and the sense that we could control our destiny enough to take reasonable risks to proceed, the benefits would have extended to our community, which is also going through an economic hurdle.

In the context of this reassurance, I would like to address the misconception that the licensing scheme

proposed in this bill, in our case 12 years, because we are a B home, provides more certainty than our current one-year licence. This is simply not the case. Renewal of our current licence is based on things we can control and influence, such as meeting the provisions of the existing legislation and our service agreement. In fact, this is how it should be, for whatever period the licence is for. The limited-term licensing provisions outlined in section 180 link the renewal of our licence solely to the structure of our building. There is no provision for what we would have to do to keep our licence or identify how long our licence would be renewed for even if we were able to do what the government might ask. In fact, as far as we know, the government could just as easily tell us it is closing our home or moving our beds to another community.

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As you know, just the prospect of this is enough uncertainty for us not to be able to proceed with a major renovation project. If this uncertainty gets cemented in legislation, it is effectively ensuring that if the government tells us to invest significantly in building renovations, we will likely be unable to comply. Even if we were, there is still no hope that we will be able to eliminate our four-bed wards and provide residents and families with the same comfort and dignity that residents enjoy in new homes with the benefit of government funding. The government already knows that requires a commitment to implement a capital renewal and retrofit program.

People have so often noted that long-term care is about commitment to people and community, not just a job, a career or a business. This is a commitment that I have known all of my personal and professional life, and it motivates me to keep moving Algonquin Nursing Home's care, services and culture forward.

Amending the limited licensing provisions to remove the uncertainty and committing government to immediately implement a capital renewal and retrofit program to renew all B and C homes would enable us to do this. I know that our association, the OLTCA, has presented a detailed and workable plan. I'm comfortable with it and I encourage you to support it.

Two elements are necessary for the residents of the Mattawa-Bonfield area to be assured that the long-term-care services they increasingly need are there for them. The first is a home that is capable of supporting the care and service levels they need, expect and deserve. The second is that within the physical structure the management and staff are able to deliver the care required while enhancing the one feature that makes long-term care unique: that it is also their home.

So far I have focused on how Bill 140 impacts the first. Janet will now address a number of issues with this proposed legislation that impact the latter.

**Ms. Janet McNabb:** First, let me say that from this perspective, there are things in this bill I fully support, things like the measures to strengthen resident safety. In fact, in many of these areas, as they say, its heart is in the right place.

Where our concerns arise is when we look at some of what Bill 140 requires in the context of the day-to-day reality of life inside our home. Our concerns range from knowing there are things we cannot deliver to the impact on care and our home environment. We're deeply concerned over what we see as government withdrawing its commitment to provide the funding that will enable us to provide the care and services that residents need. Stating that government "may" fund, as Bill 140 does, does not give us the same level of confidence as the "shall" fund wording in existing legislation.

At the same time, Bill 140 will ask us to do what is impossible even within our existing resources. I speak, of course, of what you now are all likely aware of: the requirement to provide restorative care programs and activity and recreation programs to meet the assessed needs of individual residents. The concept behind this requirement is a caregiver's dream; in long-term care now, it is only a fantasy. If it remains as a legislated requirement, without the necessary resources and with an absolute compliance program with work and activity orders and financial penalties, it is the beginnings of a nightmare. These requirements are impossible to implement on current funding. We shudder at being faced with this reality and the consequences and impact of being non-compliant.

As you know, we're a small home in a small community. Our staff, family members and volunteers work hard to ensure that our physical environment reflects the values of small-town Ontario to feel like home for the people who lived these values all their lives. It means a lot to the comfort and dignity of our residents.

While it may seem like a small thing in a big city, Bill 140's requirement that we post some 13 official and legal documents on our walls is a big thing for us. They will certainly become a prominent feature of our physical environment. In fact, families and visitors and others are likely to think they're coming into the post office or some other official building rather than a family member's home.

We understand the concept behind this requirement and the importance of families and residents having access to information. We believe a more resident-focused and less institutionalizing approach would be for Bill 140 to specify that this information should be available in the home and let the home, residents' council and families work out how we fulfill that requirement.

With respect to meeting resident needs, I would like to take the opportunity to say that we support the concerns you've heard from other homes with respect to Bill 140's impact on existing care and service levels. I can tell you that in a home the size of ours, when I have to be in my office filling out reports or going around filling out forms, everybody in the home knows it. Even now, they would like to see me have more time to listen to their needs or help them with something.

I would like to close my remarks by addressing the issue of abuse. We fully support the spirit and provisions of this bill to strengthen abuse protection. Resident abuse

is simply unacceptable and inexcusable, irrespective of the source. Our home has had a zero tolerance abuse policy for 30 years and we apply and reinforce it with all of the resources and power within our control.

But, please, let me be frank: Government's and indeed everyone else's expectations that the strength and provisions of Bill 140 will adequately address these issues are not going to be met. That is because there are two factors that impact this issue that the provisions of Bill 140 cannot reach.

The first is the requirement for the operator to protect the resident from abuse by anyone. Believe me, we would if we could. We cannot because we cannot monitor every interaction the resident has. We are quite rightly required to provide privacy for residents to visit with their families. We also have no control over the personal financial relationships between residents and others outside the home.

The second issue is the fact that right now, arbitrators have the right to allow staff who have been found to have abused a resident to return to work. If they retain this right, we can implement the full strength of everything in this bill and then have to take it all back because an arbitrator is not held to the same zero tolerance benchmark. Further, staff are going to be increasingly reluctant to come forward and report other staff if they know it is likely that at the end of the day, they're going to get their job back. This is difficult enough in a small town where they're likely to meet in the aisle of the grocery store every weekend anyway—and we only have one grocery store left. You can just imagine the emotional turmoil it's going to create if they know they're going to have to continue working with them as well.

The Ontario Long Term Care Association has submitted detailed amendments to address the specific issues Vala and I have raised. On behalf of the residents, families and staff of Algonquin Nursing Home and the Mattawa-Bonfield area, I ask that you give them your full support.

**The Vice-Chair:** Thank you very much for your presentation. We have two minutes left—one good, quick question each. Ms. Martel?

**Ms. Martel:** Thank you for your participation today and for driving to be here.

I want to focus on page 5, where you talked about mortgages. You said, "My banker is already skittish. He called me after the government's meeting with the bankers a few months ago. He was not reassured...." What's that a reference to? This is the first time we've heard about that—or that I've heard about that; maybe others know something more.

**Ms. Monestime Belter:** I believe that when the bill was first tabled—Monique, please help me out—because there's that little issue of financing, the government went with lots of different banks just to take them through the process. Our banker wasn't there, but he heard whatever was reported. He still doesn't get it. He doesn't think it makes sense. I tried to reassure him. I told him about the process—yak, yak, yak. He's spooked. He doesn't



believe there's any proof in it that I can maintain a long-term mortgage. I said, "I'm the only one in town. This will never happen."

**The Vice-Chair:** Parliamentary assistant, a quick question?

**Ms. Smith:** Just to clarify, the ministry and various government officials met with various stakeholders, including the financial community and other stakeholder groups, after the introduction of legislation for technical briefings.

Thank you, Vala and Janet, for being here, for doing the great job that you do and for providing such good care in Mattawa. I'm surprised at some of the things you had to say. For some reason, Karen and the OLTCAs seem to be quite concerned about this posting requirement. I've been to Algonquin many, many times and I've been to the Mattawa post office, and there's no way I'd be confused as to which is which.

You run a great home, and we've heard from family members and residents that they want to make sure that they have the information that they need. Not all homes have boards posting even the minimum. There are standards and requirements now that homes post their inspection reports, the bill of rights and the 1-800 number. Well, I can tell you that on my visits to over 30 homes, I've had a very difficult time finding those things posted. So I wonder about your concern around this, because our family members and residents have told us that they want to see more information. They want to have access to that. So can you respond to that—

**The Vice-Chair:** Thank you. Mr. Ouellette?

**Mr. Ouellette:** Just a quick question: You mentioned the capital expansion. What form would be needed to ensure your viability?

**Ms. Monestime Belter:** What form?

**Mr. Ouellette:** Yes, what type of capital expansion do you need to continue on in your services?

**Ms. Monestime Belter:** Well, first of all, our residents live in four-bed rooms when the rest of Ontario seems to be moving into two-bed rooms. That's discrimination, I think. The government has helped with that. I would like to see the government continue helping with the B and C homes so that we too could be equal with everyone else.

The second thing is, by tying our licence to a time limit, we can't get a mortgage to be able to do the renovations.

**The Vice-Chair:** Thank you very much for your presentation.

We're going to recess until 1 o'clock. For the people here, the room will be locked. Take your personal items with you, because nobody is allowed to come back here during this hour.

*The committee recessed from 1159 to 1300.*

#### ST. JOSEPH'S VILLA

**The Vice-Chair:** Good afternoon, ladies and gentlemen. It's exactly 1 o'clock. We are going to start with St.

Joseph's Villa. If they are here, they can come forward and start their presentation.

Welcome to the standing committee on social policy. Please, before you start, can you state your name and your friends' names for the record.

**Ms. Monique Landry-Sabourin:** Absolutely.

**Interjection:** Oh, we're not friends.

**The Vice-Chair:** Okay. You or somebody with you—

**Interjection:** I'm just teasing.

**Ms. Landry-Sabourin:** We are more than friends, sir. We work together.

I am Monique Landry-Sabourin and I am chair of the board of St. Joseph's Villa. On my right is Jo-Anne Palkovits, the CEO for the villa.

St. Joseph's Villa is unique in Sudbury. It is the only charitable non-profit long-term-care home in Sudbury. We are also the newest home in Sudbury, having opened in December 2003 with 128 beds. We are located on Laurentian University property, which affords us many research and educational opportunities. Building on the tradition of the Sisters of St. Joseph of Sault Ste. Marie, we are pleased to provide excellence, service, dignity and integrity to our residents and staff. We are fortunate to be governed by a voluntary board of trustees that is representative of the Sudbury community, including lawyers, accountants, physicians, business owners and educators who have much experience sitting on voluntary boards. Today we have with us four members of the board: Sister Mildred Connelly, vice-chair; Mimi Andrews; Al Cruthers from CHCO, and—did I miss someone?

**Interjection:** That's it.

**Ms. Landry-Sabourin:** Okay. We have a very supportive board, as you can see.

Our board supports in principle the intent of Bill 140, to build a strong, accountable and resident-centred long-term-care system. However, we are concerned that it falls short of this goal. We believe the proposed legislation is flawed, especially for the non-profit homes, and significant changes are needed if it is to have a positive effect on the lives of our residents now and into the future.

Given the limited time available to us this afternoon, I would like to focus on three key themes identified by our board.

The McGuinty Liberals, in opposition then and now in government, have consistently been very vocal in their support for not-for-profit health care delivery. We were pleased when the government put words into action by clearly establishing a preference for public health care and the not-for-profit sector in legislation such as the Commitment to Medicare Act and the LHIN legislation.

What has, quite frankly, surprised and dismayed us is not only the absence of an equivalent preference in Bill 140, but also that it will have serious implications for the viability of the not-for-profit long-term-care sector. This should be an alarm bell for the public and the government. The not-for-profit sector, including the Sisters of St. Joseph of Sault Ste. Marie, whose legacy we attempt

to live out, delivered value-added services for over a century. And in a sector that is seriously underfunded, it is worth noting that our organization is fortunate to have a foundation that supports us in topping up our operational funding to assist us to pay for cost overruns such as our food allowance. I must say at this point that the ministry allows \$5.46 per resident. We are putting in more than that. We are quite surprised that another ministry is giving \$12 per day for prisoners. There is also growing evidence that not-for-profit delivery of long-term care results in more staffing and improved care outcomes for residents.

St. Joseph's Villa is calling on the government to include in the preamble a strong and explicit statement that it is "committed to promoting and supporting not-for-profit delivery of long-term care in Ontario." In addition, we want a governing principle in the licensing section that commits the government to supporting non-profit ownership of long-term-care homes.

The second theme I will speak to relates to governance. Our board relies on community leaders who are willing to give freely of their time as volunteers to serve on the board of the villa. They represent a very diverse group of individuals representative of our Sudbury community. They are not compensated for their time or expertise.

Bill 140 will impose higher obligations—section 67—and harsher offence provisions—section 177—on the directors of long-term-care homes than any other sector in health care, including hospitals. The proposed legislation could result in directors being subject to fines up to \$25,000 and imprisonment for any breaches of the act by anyone in the home. This will make it very difficult for us to maintain current directors and attract new ones, especially since penalty provisions are not covered by standard directors' and officers' insurance in Canada. We do not understand why the government wishes to impose such an obligation on board members of long-term-care homes when this is not the standard for other boards in the province. We would recommend that we be treated equally to our health care partners and recommend that the government treat us the same as hospitals under the Ontario Public Hospitals Act.

The third theme I wish to pursue is the impact Bill 140 will have on resident care. Bill 140 proposes a significant increase in regulation. While our board supports measures to enhance standards and ensure full accountability, this legislation is so excessively onerous that the villa will be forced to shift already scarce resources to meeting new administrative demands. Staff will be forced to spend more of their time on compliance and documentation, and this will mean they have even less time available for direct care and services. We are about care and services. The villa is already challenged by inadequate funding. This additional burden of red tape will exacerbate these challenges. We are very concerned that the focus in the bill on prescriptive micromanagement is misplaced and could actually result in a lower standard of care at the villa.

At a minimum, the province must analyze what added financial burden will be placed on the villa as a result of the new regulatory demands and increase operating funding by that amount. Establishing new requirements and standards without providing the means to achieve them is only a prescription for failure. A very clear example is the call that's being made for care standards by many of the presenters. We're not the first ones, I'm quite sure, to tell you exactly this. We certainly support this direction, but only if it is fully funded for all homes.

The provision related to secure units serves as a good example. These units provide residents with significant dementias and behaviours with a safe haven and attention to their needs. Including these units as restraints will require adherence to extensive monitoring and reporting requirements. The workload implications are significant. For example, meeting the documentation requirements for a 30-bed special care unit is projected to require at least one full-time nursing position, with no commensurate benefit to resident care.

Another example is training and orientation. While we agree on the importance of the villa having knowledgeable and well-educated staff and volunteers—which we have—the level of expectation outlined in Bill 140 is unreasonable and will impose a continuous administrative burden and cost for us. It goes well beyond simply identifying requirements and delves into the specifics of exactly how orientation and training are to be conducted.

In concluding my remarks, I want to make very clear that while we are moving in the right direction with new legislation for long-term-care homes, we are on the wrong track with Bill 140. We are very concerned with provisions in the bill that disadvantage not-for-profits such as ourselves, and with the many sections that are so prescriptive and excessively onerous, with no significant improvements to care. We must all—government, providers, consumers and their families—work in partnership to create legislation that enables and encourages innovation, flexibility and excellence in the delivery of long-term care in Ontario.

Thank you for listening. I'm quite sure I've repeated some things that you have already heard, but it was very important for us to let you know where we stand.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can divide it equally among the three parties. We start with the parliamentary assistant.

**Ms. Smith:** Thanks for being here. I wondered about the comment in your conclusion that "We are very concerned with provisions in the bill that disadvantage not-for-profits." What provisions specifically in the bill do you think disadvantage not-for-profits?

**Ms. Landry-Sabourin:** I will let our CEO answer that question because she's on the administrative side.

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**Ms. Jo-Anne Palkovits:** I think a lot of the things around the standards of care that are in there around documentation and things like that.



Again, we have very limited dollars. All the dollars that we currently have right now go into our staffing. We have zero-based budgeting, so there are no excess dollars, for example, right now to hire extra staff for documentation and the like that is required according to Bill 140—perhaps compared, at least in our opinion, to some of the for-profits, who may have some excess revenues that are now going to stakeholders whereby they could actually use those dollars to hire that staff. As I indicated, right now we have a zero-based budget so all of our money is currently being spent directly on care.

**Ms. Smith:** But that's for your budgeting purposes. You're actually funded the same way as the for-profits, as far as based on your CMI and the care needs of your residents in your home. Isn't that correct?

**Ms. Palkovits:** Yes, we are funded the same. But as I said, right now we have to rely on our foundation because we're just not able to meet the food costs. As an example, our foundation has very specifically passed a motion whereby any funds that come into our foundation offset the additional costs for food. So instead of what we're currently being provided—I believe that our food costs at year-end were approximately \$6.20 a day, so obviously you can see the gap there. When you multiply that by 365 days and 128 residents, obviously that's a significant amount.

**The Vice-Chair:** Mr. Ouellette.

**Mr. Ouellette:** Just a quick question on your presentation. In your opening remarks you mentioned that, because of your location, you're able to do research and educational opportunities. Can you just kind of expand on what takes place there or what you may have been able to find out that can improve the system from that experience?

**Ms. Palkovits:** I certainly will. First of all, we're very fortunate that we are on Laurentian University property. I'm sure you're aware that we have a new Northern Ontario School of Medicine. We're located right across the way. So we actually have formal partnerships in place with the school of medicine, the school of gerontology, the school of nursing, the school of biology, the school of business as well as a variety of several of the colleges in town. But being on the Laurentian University property particularly has enabled us to actually undertake several research projects which are currently on the go. I believe that's probably because of our close proximity, because it makes it very easy for the students and the professors to access our site.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for being here today. How much does the foundation top up outside of the food allowance? Do you also do that directly for staff?

**Ms. Palkovits:** We do not for staff, but they do assist us in terms of some of our purchases. For example, they have assisted us in purchasing lifts, beds, a lot of things particularly with our activation department because, as you know, that's a very strict and, I would say, small budget. So they've helped us in terms of buying. It may sound simple but, for our residents, it's very important in

terms of being able to go on outings. They were instrumental in purchasing a handi-bus for us so that we could take our residents to a variety of outings. Again, without our foundation we would not have been able to afford those things.

**Ms. Martel:** With respect to the penalty provisions, what does your board think? Are they going to stay on if the provisions stay the same?

**Ms. Palkovits:** I can't speak for my board.

**Ms. Landry-Sabourin:** I think everybody on the board would think about it twice.

**The Vice-Chair:** Thank you very much for your presentation.

#### SUDBURY HEALTH COALITION

**The Vice-Chair:** We'll move to the next presentation, by the Sudbury Health Coalition. They are not here in person; they're going to do it through teleconference. I believe we have with us Anne-Marie MacInnis, the chair. You're on and you can start any time you want.

**Ms. Anne-Marie MacInnis:** Good afternoon and thank you. The levels of care provided to residents in long-term-care facilities have dramatically changed. Residents are diagnosed with multiple diagnoses and prognoses. As a health care worker in a long-term-care facility for 25 years, I want to give you a detailed account of a 24-hour period in the life of a resident in a long-term-care facility across this province. In an effort to maintain a general flow of information, when you hear the word "staff" or "worker," I am referring to the hands-on care providers.

Generally at 6:55 a.m., staff receives a report from their supervisor, which includes changes to a resident's condition and/or behaviour or appointments that have been scheduled. The staff receives an assignment sheet and is responsible for providing care to a minimum of eight residents, up to 14. They begin gathering supplies such as facecloths, towels, bed linens and topical medications and proceed to wake up the residents.

In the ideal world, a staff member would go into the resident's bedroom and begin to turn on the over-bed nightlight or open up the curtains while speaking to the residents in a soft voice in an effort to gently wake them up so they can begin to provide care. The worker should not be rushing care, because the resident has not been mobile for hours and will experience stiffness and pain. A gentle approach will decrease the anxiety of a resident and also reduce episodes of aggression.

The assumption is that all residents understand and speak English. Sensitivity towards language and cultural needs are important in order to overcome communication and behavioural barriers. The resident may refuse care for many reasons and staff should respect that and return at a later time. At all times, staff are to provide encouragement and promote personal independence.

All residents, as outlined in policies and procedures, are to receive a.m. care. Staff are expected to wash the resident's face, hands, back, armpits and private area and

observe for changes in skin condition, such as redness or ulcers, changes to their eyes, ears etc. The hands-on care providers are the people who initially become aware of these changes and must report this information promptly. If the incontinent product is 80% wet, then the resident can receive a clean, dry product. Body lotions and/or topical medications are then applied.

The resident has the right to go to the common dining areas in their day clothes so the worker dresses them. The resident may be assessed and a decision made to use a mechanical lift on the resident for their safety and the safety of the staff. If this is identified in the personal care plan—most facilities have a no-lift policy, which means two workers should be present; one will manoeuvre the machine while the other spots. Once safely in their wheelchair or geri-chair, staff will comb their hair and provide mouth care. The worker may get their toothbrush and toothpaste and set up the resident in the bathroom to provide their own mouth care with constant encouragement. If the resident is unable to do this, the worker should brush their teeth or dentures, swab the interior of the mouth cavity and examine the condition of the mouth and gums. Fingernails should be inspected, and trimmed or cleaned if necessary.

The worker is to provide the equipment, give encouragement or shave the residents who have been assigned to them. Once a.m. care has been completed, the worker will turn on the radio or television in the bedroom or porter the resident to the common dining areas, where they will sit waiting for the meal to be served. Keep in mind that the worker must complete care for eight to up to 14 residents. The care described above is for one resident only.

The Ministry of Health has outlined specific time frames when breakfast, lunch and supper are to be served. Staff are expected to be in the common eating areas at 8 or 8:30 a.m. Some residents are able to feed themselves with minimal assistance and supervision, while others have to be fed. Staff must provide constant encouragement and supervision and be aware of special diets or swallowing difficulties. The workers serve and feed the residents and clean off tables before serving the next entrée. The dining experience is suppose to be positive, quiet and not rushed. Food and liquid intake is then recorded on sheets.

Some facility operators have cut several hours in the dietary department, and while the residents are eating or being fed, there is clanging of pots and pans and dishwashers are running. The residents are supposed to have a choice at mealtime. More often than not, they do not receive their preference because only a certain amount of each choice is prepared. The worker must then try to explain to the resident why they can not have their first choice. The general expectation is the meal should be served and residents fed in one hour. Breakfast is served to 30 to 32 residents, depending on the size of the facility.

At 9:15 a.m., staff are entitled to begin taking their 15-minute break. More often than not, workers will continue

working through their break time in an effort to not fall behind. Some units will only have two workers for the entire eight-hour shift. If a worker takes 15 minutes for their break, the care is limited until there is a full staff complement.

After breakfast, staff then porter the residents back to their rooms and continue providing a.m. care to the residents they could not help before breakfast. Staff must also toilet all residents or change their incontinence product if the indicator is 80% wet. Staff are expected to visually check residents hourly or physically re-position them every two hours if they are unable to move on their own.

Every resident in a long-term-care facility is to receive two baths or showers per week, whichever they prefer. The second bath or shower is to be offered, and if the resident refuses, a bed bath is acceptable by most nursing home operators. Staff must ensure that a bath is provided for the residents who have been assigned to them for the day shift.

It is now approximately 10:15 a.m. and nourishment must be given to all residents. Staff are to supervise, assist or administer the fluids or snacks. At no time are liquids or food to be offered without supervision, because of the possibility that a resident may choke. Food and liquid intakes are then recorded.

It is now approximately 11 a.m. and staff begin to take their unpaid half-hour lunch break. The remaining staff on the floor continue to provide a.m. care: baths, showers, re-positioning, answering call bells or changing the resident if the incontinence product is 80% wet. Throughout the entire eight-hour shift, they are to report any unusual physical or behavioural changes and answer call bells.

It is now approximately 12 p.m. and lunch is provided to residents. Staff porter the residents to the common dining areas and record their meal choices. Coffee, water and milk are served, and then the main course. Some staff remain in the dining room, while others go down the hall to feed residents. The food and liquid intake is then recorded.

At approximately 1 p.m., staff begin portering residents back to their bedrooms and toilet or change the incontinence product if it is 80% wet. Some residents will be placed in bed and their day clothes will be changed if dirty; others will remain up and should be physically repositioned. Workers who choose will begin to take their much-needed last 15-minute break; others will continue to work through their break.

Each time an incontinence product is changed or a resident is toileted, staff should provide peri-care. When a resident pulls their call bell, it should be answered promptly.

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At approximately 2 p.m., afternoon nourishment and snacks must be served. Staff must supervise and assist. The intake is then recorded. Staff must then document activities of daily living and document the care that was provided on their residents and report concerns. At all



times, workers are responsible to keep the entire living space and work areas clean and safe for the residents, visitors and co-workers. Other assigned duties include bed making, bed changes, ensuring rooms and bedside units are clean and tidy, putting away personal clothing and ensuring that the call bell is easily accessible to the residents and in good working order.

The afternoon shift and night shift workers have a different routine, and the staff-patient ratio, of course, is increased.

A high number of workers will report to work 15 or 20 minutes earlier than required, they will work through their 15-minute breaks and lunch periods and stay longer than eight hours to complete care and documentation for fear of being disciplined, suspended or terminated. Some nursing home operators take advantage of the good nature of the workers and demand more work with less staff, i.e., not finding replacements unless more than one worker has called in sick. The workload is overwhelming.

Some staff have immediate family members or friends who live in long-term-care facilities. They are not allowed to participate on family councils, even though this is supported by advocate councils and family council members.

The 24-hour period described above is a normal day and does not include changes in a resident's condition and/or behaviours, flu outbreaks, infectious diseases or when a resident becomes palliative and is nearing the end stages of life.

Workers in long-term-care facilities are cutting corners in order to provide some kind of care to all the residents whom they are responsible for. I have heard stories of women who are giving birth to multiple babies. It is heartwarming to hear how the community will come together and local business owners will give free food or diapers for a year or a car dealership will donate a minivan.

Have you ever heard the saying "once a man, twice a child"? Residents are diagnosed with Alzheimer's or other cognitive impairments and are becoming increasingly frail, and levels of care regress to that of a child.

I applaud the efforts of the government regarding Bill 140. The ministry requires facilities to meet minimum standards when constructing a building, i.e., door frames, the size of the bathrooms, how high the window can be from the floor. I am appealing to the government to legislate a minimum staffing standard of 3.5 hours of care per resident per day for current and future residents who will be calling a long-term-care facility in Ontario their home. This will begin to ensure that residents will receive dignity and that workers can adequately begin to meet the residents' physical, psychological, social, cultural and spiritual needs.

**The Vice-Chair:** You've left six minutes; we are going to divide it equally between the three parties. We'll start with two minutes for Mr. Ouellette.

**Mr. Ouellette:** Thank you very much for your presentation. Your comments regarding the specific time

frames, with breakfast, lunch and supper to be served: Do you think that will increase the number of part-time workers in order to comply with those guidelines at those times?

**Ms. MacInnis:** Increase part-time workers? I don't understand your question, because I don't see how that would happen.

**Mr. Ouellette:** I don't know how you'd be able to fulfill the expectations in the time that's allowed to provide that service unless you had individuals who could come in for those times specifically.

**Ms. MacInnis:** Right now they do have short shifts, and a lot of times those short shifts are scheduled around meal times, specifically to help with that. Would it increase that? I'm not too sure.

**Mr. Ouellette:** The other thing is the start. You mentioned that when they come in in the morning, they receive the documentation at 6:55, which includes the changes to a resident's condition or behaviour or appointments. Who does the condition or behaviour changes through the evening, when those individuals leave, so that they can pass that on to the person who's providing the care?

**Ms. MacInnis:** Generally, it's on a census report, and it would be the registered nurse in that unit who would give a verbal report to the workers prior to their shift.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you, Anne Marie, for the presentation. In terms of what's happening right now in homes, if someone calls in sick, are they being replaced or are the other workers, more often than not, just picking up the slack?

**Ms. MacInnis:** I can't speak for every home, but a lot of nursing home operators have plans. If one staff member calls in sick, the directive to the registered staff is, don't call people in. Some facilities say that even if two people call in sick, don't call until the third person calls in sick. So what happens is that staff are working short, and we're not given any kind of clear directive. After you leave work the day before and you've taken care of eight to 14 residents, you're pooped and sometimes you're unable to complete all the care provided on that day. The next day, when you come in, if they're not replacing staff, obviously your workload has increased, the staff-patient ratio has increased. We have said in the past, "Then prioritize for us, because you know what? Yesterday I was hardly able to complete the care, and you're asking me to provide it for another eight people. It's impossible. So you prioritize what is priority and what's not." But nobody will do that, so corners are cut.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** Thank you for your presentation today. We've heard a lot of discussion about the minimum standard and the 3.5 that you talked about in the final part of your presentation. I just wondered what you would include in a calculation of a minimum standard. Would you include the director of care, the RN on call, the RPNs, the personal support workers, the bathing people

in some homes, the dietary, the activation? Which organizations or groups would you include in that number?

**Ms. MacInnis:** That is a really good question. I have no background or experience in dealing with budgets, but the 3.5 hours of care that I believe is needed as a minimum staffing standard is specifically for the hands-on care providers.

**Ms. Smith:** And how would you define hands-on care providers?

**Ms. MacInnis:** PSWs, health care aides, PCAs. There are several different names for the care.

**The Vice-Chair:** Thank you very much for your presentation.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 146

**The Vice-Chair:** Now we'll move to the next presentation, by the Canadian Union of Public Employees, Local 146.

**Mr. Henri Giroux:** Sit anywhere?

**The Vice-Chair:** Yes, and you can start whenever you're ready.

**Mr. Giroux:** Good afternoon. My name is Henri Giroux and I'm from North Bay. This is Brian Blakeley, from CUPE research.

I work in a 240-resident home for the aged, and have been there since 1979, which is 28 years ago. I'm also the president of CUPE Local 146 and we have approximately 185 workers. I'm also the North Bay and district CUPE Local 9126 president. We have approximately 11 long-term-care facilities. We are all proud workers of long-term-care facilities, but we also see that there are some things missing in this legislation and that it needs some amendments. In addition, CUPE members are residents and users of Ontario's health system. Many of us have family members, colleagues and friends living in Ontario's nursing homes.

The continued movement of heavier-care patients out of hospitals and mental health facilities into long-term-care homes has created mounting care needs that remain unmet.

In its present form, the proposed legislation fails to provide the statutory and regulatory framework that would achieve the safety of our residents and staff in Ontario's homes. It fails to ensure even minimal accountability for meeting the residents' assessed needs and improving government accountability:

- It provides no rights to access any level of care at all.

- It abandons promises to re-establish care standards and compliance regimes to ensure these are met.

- It fails to protect residents, staff, family members and visitors from an inexcusable increase in violence, illness, accident and injury in our homes.

Local 146 and other locals in our area believe that the key focus of any long-term-care reform must be the provision of a minimum staffing standard to ensure adequate care levels, a mechanism to measure and provide

adequate funding to reach these staffing standards, and a compliance regime to ensure they are respected.

Staffing levels are the key to providing sound care, to preventing abuse and neglect, to ensuring the safety of residents and care workers, and to improving the quality of life of the residents. The government must recognize that the homes are also a workplace where the current levels of care are inadequate and unsafe and that the rate of illness, injury and violence in facilities must be recognized and prevented.

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To ensure that the care needs of residents are met and to fulfill its obligations to provide sound oversight and accountability for the use of public funds, we recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day per resident of nursing and personal care. This is to reach the goal of risk prevention. It is not an optimum.

In addition, the government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive and staff them with sufficient numbers of appropriately trained workers.

Heavy workloads mean that there is not enough time to complete tasks in a way that complies with standards. Nearly one in five workers reported that they are able to complete their tasks to established standards less than half of the time. An additional 14.3% report that they are never able to do so. Nearly 60% of the time, workers don't have time to provide emotional support. More than 50% report that work caused illness or injury more than 11 times during this time period.

The proposed legislation must tackle the serious issues of understaffing, illness and injury revealed in the research. It is unconscionable for the government to knowingly allow the continuation of inadequate regulation that has created understaffed workplaces in which caregivers are punched, kicked, spat on, pinched, bitten, slapped, injured and made ill while attending to provide care. Long-term-care facilities are workplaces where workers are entitled to health and safety, freedom from violence and abuse, proper work supplies, sufficient staff resources and support.

While the proposed legislation includes provisions to deal with the mandatory reporting of abuse and undefined neglect, it fails to address the serious problem of violence in long-term-care homes. The goal should be prevention of violence, not simply reporting of incidents of violence. There is an urgent need for the new legislation to explicitly recognize increased violence in facilities. Neil Boyd, a criminology professor at Simon Fraser University, who is studying physical abuse in the health care sector, says that the main reason for increasing violence is the aging population. He says that abuse of workers occurs most frequently in long-term-care facilities where residents have disabilities such as brain injuries, age-related dementia and chronic progressive disease.



We recommend that section 5 of the proposed legislation be amended to require that homes be safe and secure for residents and staff.

In addition, the safety of residents, our members, family members, volunteers and visitors require that the new legislation provide access to all standards for special-care units or facilities; clear, appropriate training guidelines and improved training opportunity; the establishment of care plans for those with a history of violence prior to admission; and stop the inappropriate down-loading of patients from mental health facilities and acute care facilities into long-term-care homes. More care must be allocated to those with dementia and other cognitive impairments that result in agitation and aggression.

On a personal note and closer to home, in our facility we have a staff ratio of one worker for every group of 13 to 14 on a day shift and a ratio of one worker for 19 on the evening shift. Imagine how much care we can give with these figures.

Violence in the workplace occurs almost every day but it is sometimes left unreported because the residents are like family to us. Would you report your grandmother if she happened to slap, kick or spit at you?

Health and safety: We had almost eight to 10 health care workers with 10 to 20 years of experience who had to leave their employment to re-enter the labour market because they had hurt their back, spine or neck because of the workload and there is not enough modified work for them to stay at the workplace. Being in the labour market is a price to pay for an employer and also causes a lot of stress on families. An injury to one is an injury to all.

Please make the proper amendments to this legislation so that we can have a safe environment for our residents and staff.

**The Vice-Chair:** Thank you very much. We have six minutes left which we're going to divide equally. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for driving here today. I appreciate your participation.

When you talk about eight to 10 health care workers having to leave their employment, what was the time period for that?

**Mr. Giroux:** In the last five years.

**Ms. Martel:** Okay. Let me talk about the staff ratio of one worker for every 13 to 14 on the day shift and one to 19 on the evening shift. How long has that been in place? That's a very high proportion, higher than we've heard in terms of responsibilities of staff to residents.

**Mr. Giroux:** It's been a couple of years now. We try to staff them, but the problem is that if the case mix index goes down, staff get laid off and then you're back to square one. We have experienced that in the past and we're hoping it doesn't happen again, because we heard the case mix index might have gone down again.

**Ms. Martel:** So that one for 13 to 14 and 19 has been in place for two years, three years?

**Mr. Giroux:** Two years.

**Ms. Martel:** And that's directly as a result of the case mix index declining and staff being let go?

**Mr. Giroux:** Yes.

**Ms. Martel:** How many staff were let go?

**Mr. Giroux:** We had two RPNs and one health care aide. They were later rehired, but the work was still there for them to—

**Ms. Martel:** But you're in a municipal home for the aged, right?

**Mr. Giroux:** Yes.

**Ms. Martel:** What's the top-up? Do you have any idea what the top-up might be from the municipality to help in the operation of the home, and what the money's going towards?

**Mr. Blakeley:** We don't have any information on that.

**Ms. Martel:** Because normally you would see that top-up replacing those staff, at least in a municipal home for the aged.

**Mr. Blakeley:** That's still driven by council decisions in the area. So I'll find out for you.

**Ms. Martel:** That would be helpful; thank you. That's it. Thank you very much.

**The Vice-Chair:** Parliamentary assistant.

**Ms. Smith:** Thanks, Henri. It's nice to see you today. You stated in your presentation that the legislation "provides no rights to access any level of care at all." I would just take exception to that because, if you look at section 6, we set out how the plan of care for each resident is to be determined. It's to be based on the assessed needs of the resident, and every licensee is to provide the care that's required in a plan of care for residents. So there is a requirement that every licensee or every home provide the level of care that the resident requires, as assessed. I just wanted to point that out to you.

You also in your presentation were looking for "clear, appropriate training guidelines and improved training opportunity." I would just direct you to subsection 74(6), where we outline the type of training that we believe front-line workers should be receiving in all of our long-term-care homes across the province.

You also were looking for a requirement for "care plans for those with a history of violence prior to admission." I would just note that in subsection 41(4) we have extended the requirements for assessment prior to placement in homes and we include as one of the assessments the applicant's functional capacity, requirements for personal care, current behaviour, and behaviour during the year preceding assessment so that we have a better assessment overall of the resident's needs, both behavioural and physical, and can ensure that the placement is appropriate for that resident. So we have taken some of those considerations into account in this piece of legislation. I just wanted to point that out to you.

Thank you for coming.

**The Vice-Chair:** Mr. Ouellette?

**Mr. Ouellette:** You mentioned staff and the ratios of one to 13 and 14, and one to 19, and that individuals were laid off. When that took place, were they replaced with part-time individuals or not? Or do you know?

**Mr. Giroux:** No, they weren't replaced.

**Mr. Ouellette:** So no replacements took place at all to make sure that the level of care was maintained.

**Mr. Giroux:** No.

**Mr. Ouellette:** The other thing is, on that same page, page 6, you mentioned to stop the "inappropriate down-loading of patients from mental health facilities and acute care facilities into long-term-care homes." Do you know what kind of a percentage relates to the individuals who you feel are in the homes now who shouldn't be there?

**Mr. Giroux:** I don't have the percentage right now; I could get you that. But the problem with that, we feel, is we have long-term staff and they're not well trained for that kind of patient. So that's what makes it a lot harder to work with that kind of patient compared to when people started there 20 years ago and they had old people and that's it.

**Mr. Ouellette:** Those are all my questions, Mr. Chair.

**The Vice-Chair:** Thank you very much for your presentation.

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#### BETTY MOSELEY-WILLIAMS

**The Vice-Chair:** We move to the next presentation. It will be by Betty Moseley-Williams. Welcome. You can start whenever you're ready.

**Mrs. Betty Moseley-Williams:** Good afternoon and thank you for the opportunity to share some of my thoughts and concerns with you regarding long-term care.

I do not believe there is a bottomless pit of money, but the shortfalls are too evident and it will take money to ensure the care provided in Ontario long-term-care facilities is, at the very least, adequate. But the aim should be excellent and equal care for all the residents, and it's not.

My name is Betty Moseley-Williams. I am 73 years young, and I worked as a nurse for over 50 years. I do not represent any group or organization. My comments are personal and they're with respect to the dealings I've had with long-term care over the past while.

I want to start by telling you a story of a conversation, and it's a true one. About 11 years ago, I was sitting with my sister, who was dying; we were planning her funeral. Being a sister, I was kind of teary. She put her hand over and said, "Betty, don't cry. I know where I'm going. You don't have any idea; my worst nightmare is that I will sit with paper panties in the hallway with a blanket half covering me, tied in a chair." I've thought of that a great deal over the last 11 years, most especially over the last year. I have to say that Mary's worst nightmare became reality for all of us.

Over the past 12 years, our family has dealt with a loved one suffering with dementia and Alzheimer's disease. The final year of his life was in three long-term-care facilities. He was lucky that his wife became his strong and vocal advocate. She is a very caring, but tough lady. She also spent \$1,000 a month over and above

everything else to help him so that he would have fresh fruit every day, that somebody would be there to help him and that he didn't have to be tied into a chair. She bought the chairs that were required—I think the two of them were around \$5,000—so that he could be in comfort and with all of the dignity that he should have.

I'd like to make my comments and suggestions on parts of this bill. I'd like to talk to the mission statement, the family councils, the daily care and the inspection and assessment.

I believe the mission statement should be developed with input from the patients, residents, families of patients, staff and some people from outside any part of the long-term-care facility. The statement should have clarity regarding the purpose and objectives of the facility. I believe the statement should include that this is the home of residents and that all will be cared for with respect, they will be treated with dignity and their pride will remain intact. I personally would like to see the words "loving care," but I expect that would offend some people because of what we have done to the word "love"; so I will be satisfied with "caring," "respect," "dignity" and "pride." I think it should be at the entrance of every home, well displayed on every unit, well framed, attractive and it should say, "Look at me. This is who we are." It should be read by everybody.

It would be helpful if there was a bulletin board. I didn't realize there were that many statements that had to be posted. However, I think there are places in Ontario that could teach people how to do a bulletin board that wouldn't scare you to death.

I think the mission statement should be examined with the policies of the facility, and if the policy does not compliment the mission statement—if they don't complement each other—then the policies need to be looked at. They should blend and they should be married.

When we talk about physician care, I believe that all of the patients being admitted to the facility should be physically examined by the facility physician, regardless of what other documents come forward. The family member who has been the caregiver should be present at that examination. Usually that caregiver would know the patient's reaction to taking meds, and the doctor needs to know what works best for the patient.

While at home, the caregiver has been working with the family doctor and they can share the experiences that work. The orders can be written at the time of admission to allow the med nurse or the nurse in charge to use some discretion in dispensing medicine or other treatments. They react so badly if things are not done just the way they're used to them being done.

Very often, this information would help the attending staff when difficulties arise. We know that anger in these patients can be very quick. Caregivers have lived with the patient during the progress of the disease and their experience has given them some expertise in the care—what works and what will not. The caregiver wants to know the days the doctor comes to the facility and they want to know how they can speak to that doctor. There is



a terrible feeling of frustration—and I think “despair” is not too strong a word—when there are questions and no one will take the time to answer them. The caregivers need to be respected, and if they knew their knowledge of the patient was listened to, the respect would be reciprocated.

I think every facility should have a family council. Perhaps the proposed office of the long-term-care homes could make this part of their mandate, but look at the present councils and prepare a report on best practices which could be used for new councils to get started. I believe that family councils could and would assist the facility in its provision of care. Families know the problems they had in being providers of care. They have to appreciate that the facility has problems also and that by working together, much good would happen for the patient.

Another suggestion would be to hire a volunteer coordinator. The last time I recommended that to anybody, I ducked all the eggs that came flying. However, I think they could be hired, either full- or part-time, to work with the family council and staff to build a volunteer group that will give the commitment and belong to it, and the home will know that they have this many volunteers coming in each day. They could help with the daily care. I know insurance would have to be a part of any volunteer program if volunteers are to help with actual care. I think that's possible. I think it can be done; it just takes a little negotiation and work. There would need to be some training in the areas the volunteer would be working in.

In the matter of daily care, there's just too much to look at—unless you want to stay for a week.

I believe the bill of rights must be posted with the mission statement on the bulletin board and again on every unit. The fact that a patient has only three diapers allowed for a 24-hour period is scandalous. Toileting is a problem for some of the patients, but there has to be a better solution. When a person sits in their own urine or feces for long periods of time, the resulting skin breakdown should not surprise anyone, and it raises the question: Is this abuse, and abuse by whom?

Bathing patients using anybody's soap or deodorant is a great way to spread bacterial infections. Patients have their own toilet articles, to be used by them. We talk a great deal and we put up signs in every public building about washing hands, about cleanliness and about spreading bacteria. In facilities, the protocols for all personal care, including bathing, must be clear.

I think skin problems will be observed soon enough without daily washing. I find it difficult to comprehend how adequate cleansing is accomplished if the diaper is changed where the patient is standing, and there is not much dignity in that process. Record-keeping for patients' skin breakdown treatment and progress should be charted and updated daily. Bedsores are often the result of poor care, insufficient diaper change and patients left for long periods in soiled diapers.

Taking patients out of their rooms when they are not properly dressed, either in night clothes or day wear,

cannot be allowed. There is no pride or dignity allowed when a patient is paraded or taken through public hallways in their underwear. Patients with hearing and/or vision loss should be approached appropriately. In our family, a hard-of-hearing dementia patient was repeatedly approached from behind for diaper change. Done while he was standing, the patient could not hear or see the staff approach, and often—every time—reacted negatively, as would anyone whose pants would just be pulled down without any warning. Again I ask: Is it abuse? If it's abuse, who is it by?

1350

I know how hard the staff who are doing the daily routine work. It's tough work. It is obvious to me that they need help and special training, and I don't believe this legislation is going to go far enough for that.

I don't know what the training or qualifications required for LTC staff are. I looked at the programs that are being taught for health care workers or health aide workers, and as far as dementia and Alzheimer's, I wasn't really impressed. I think all of that has to be examined. The training needs to address attitudes and it needs to be ongoing in the facilities. When students in any training or learning program or any type of career college are going into long-term care for their on-duty work, I think the supervision has to be with the people from the college who are teaching them. I don't think it's just turning them in there with a uniform and saying, “Now you're learning.” It might make the professional development more meaningful if all of the staff were expected to be involved in presenting to their colleagues.

I worked in an emergency department for many years and when they told us that everybody in the department was going to do professional development, I thought, “If that custodian is going to teach me something when I've been here 25 years, we're going to have a little bit of thinking here.” Well, he did. We learned a lot from each other. We learned what worked and we learned what made work difficult for other people and we made the emergency department work better.

I believe the staff of the long-term-care homes should be full-time, with a minimum of part-time people. Most of these patients do not deal well with change, and different staff every day is unsettling for them. The staffing must recognize that there are both male and female patients, and the staff has to reflect this. Too often we accept that it is not the best to have a male attendant looking after a female, and I agree with that, but I think it works the other way. In the term our family dealt with, there was never a male attendant looking after this male patient.

I agree with the proposed annual inspections and assessments. I believe the resulting report, with recognition of all the positive practices and any recommendations for change, should be available to all residents and family, as well as to prospective residents. This report might be a good time for the administrator to be invited to a meeting with the family council to discuss the report and to listen. I know there are many good things

happening in our long-term-care facilities, but even one bad accepted practice is too many.

I do thank the men and women who work so hard to care for these very vulnerable patients, but help in the form of ongoing in-service training is needed and I hope your committee will see the need for changes in the system. You need to be visionaries about what could be the norm in long-term care. You need to make us take risks and try things that would make life better for all of our residents in our facilities.

I have felt a great deal of anger and a large measure of frustration over the past year. Thank you for this opportunity to share some of this with you, and thank you for caring enough to sit on this committee. We are counting on you.

In the last years I've spent a lot of time with a severely handicapped person. We went out for coffee and walks—well, I ran and he drove his chair. At first, when he had to be admitted to a facility, we cried the whole morning. Actually, he prayed that he'd die; he didn't. And then we laughed a lot and he made the best of a not-so-great deal. We used Louis Armstrong's song "Prayer of Thanksgiving" for what we were able to share.

I see skies of blue  
and clouds of white,  
the bright blessed day  
the dark sacred night,  
and I think to myself  
what a wonderful world.

And then we said amen.

I believe that all long-term-care facilities, with more help, such as better funding and realistic support, can help all of our resident patients and their families see the possibility of a caring, wonderful world. Thank you.

**The Vice-Chair:** Thank you very much for your presentation. There is no time left for questions. My apologies. Thank you.

#### BELVEDERE HEIGHTS HOME FOR THE AGED

**The Vice-Chair:** We'll move to the next presentation. It will be by Belvedere Heights Home for the Aged. Welcome, sir.

**Mr. Peter Spadzinski:** Good afternoon. From the outset, I must confess a bias. My bias comes from having spent 18 years on municipal council, 15 years as mayor. I retired in 2003—voluntarily, I should say. Within about six months I was asked to join the board of our long-term-care facility. Within another three months, I found myself as chair. Last year at this time, we had an annual municipal meeting, at which time I announced to the assembled former colleagues that we were raising their municipal levy by 63%. We had another session with these municipal representatives last Thursday night in Parry Sound and we announced to them that we were raising their municipal levy by 55% this year. And that did not take into account a drop in the CMI from 89 to

83, which was announced after we finished our budget process.

So when I come and speak to you about Bill 140, I can tell you I bring a bias. It is very difficult for me to consider this bill seriously in light of the gross underfunding of our long-term-care facilities. There's a saying that it's easy to talk the talk. What I want to suggest to the province is that if you want us to take Bill 140 seriously, you must begin to pay for the walk.

One of the things that concerns us as a board is that we are dealing with declining resources, but the care must continue. Because people no longer need quite as much medical attention, and it seems to me that most of our funding is determined by that, that does not mean that we turn down the heat, we turn off the lights, we stop feeding them good food. Yet the funding formula, the funding provisions, the way funding is determined to a great extent seems to have that as a mindset. The CMI system does not recognize all of the realities of funding a long-term-care facility. In light of that, when we are told now by someone that we must increase our administrative functions, my question is—and this was my response to one of the mayors last Thursday night when he said, "You're not doing well enough. You go back and you sit down with your budget and you reduce it from 9%," which is what the increase was of our actual budget, "down to 3%. What are the things you're going to cut out?" I said, "That's a very simple thing for me to say to you tonight. You tell me whether we should heat the place, have lights on, feed the residents, have nurses on staff. Which one of those do you think we should eliminate?"

So when someone says to me, "By the way, in order for better care for our seniors, you're going to be doing more recording," I say, "There's nothing wrong with recording, but if people are recording—to use an old army cliché, if you're marching, you're not fighting. If you're recording, if you're writing on paper, you're not providing care."

If you want, as Bill 140 suggests, more recording, more accountability, it's time that the province put its money where its mouth is. If you want us to take Bill 140 seriously—and we ought to—you must understand that homes like Belvedere Heights have declining resources, and we cannot take seriously a lot of the suggestions—not the suggestions; the proposals—that are in Bill 140 until you make it clear as to how these things will be funded.

Municipalities will no longer accept the kind of increases that we announced last week. I live in a municipality that has just informed me that I will be paying over \$5,000 more for a water system that came as a result of Walkerton. That's my own share of the costs. At the same time, I was told that my water costs would be over \$100 a month. For me then to go to those same municipal councillors and say to them, "And by the way, we have now more than doubled your municipal levy over the last two years," you can well understand the kind of reaction that we are getting.



1400

Again, I know I perhaps bring a different perspective on a lot of these things. I've been around for a while, and I'm not naive when it comes to certain things.

I would suggest to you that with regard to some of the proposals within the legislation concerning the penalties for board members like myself—I'm a volunteer. I do not need to do this to get my jollies. I do it because I care about seniors—I'm getting close to that age myself—and I want to provide a good home for our seniors. For someone to suggest to me that I could be imprisoned, incarcerated, that I could be fined up to \$25,000 for not exercising due diligence—I would suggest to you that the people who are underfunding our current system perhaps are the ones who ought to face that kind of penalty. It's like me saying to my child, "You must eat vegetables. You must eat fruit. You must wash your hands. And now, here's a piece of paper, and I want you to record how often you eat those vegetables and fruits, but I'm sorry, there's no money for the fruits or vegetables or the paper on which you're going to record what you are doing."

If you want us as a board, the municipalities as an entity, as owners of a long-term-care facility, to take seriously what you are proposing in Bill 140, as I said at the beginning, you can't just talk the talk; it's time that you started to fund the walk adequately. Otherwise, it'll only be seen as hypocrisy. Eventually, hypocrisy leads to a lot of contempt and neglect.

I would suggest to you that it is time that the province took seriously the care of senior citizens, as was promised in the last election. Since that election, the funding has gone down disproportionately. For some residents and for some homes, it has gone down dramatically, and the levies to municipalities have gone up in an incredible way. It's time that we took long-term care seriously and paid the price as a society.

**The Vice-Chair:** Thank you very much for your presentation. We have six minutes left. We'll start with the parliamentary assistant; two minutes.

**Ms. Smith:** Belvedere Heights in Parry Sound is a new home. Is that correct?

**Mr. Spadzinski:** Yes, it is. It opened in 2004.

**Ms. Smith:** Prior to that, was there a previous incarnation of Belvedere?

**Mr. Spadzinski:** Yes, there was. It was a D facility, as a matter of fact, so it was replaced. The old building is still standing, and the board is dealing with what to do with that old portion of the building. But there is a new facility, yes.

**Ms. Smith:** Do you run other programs at Belvedere other than long-term care? Do you run a day program for Alzheimer's or Meals on Wheels?

**Mr. Spadzinski:** Yes, we do. We have Meals on Wheels. We have a hospice program. We do run other programs in conjunction with our own operation.

**Ms. Smith:** As do a lot of municipal homes. But those don't come under the long-term-care mandate, so we appreciate that you're doing that.

We have invested, as I've said a number of times today—I don't know if you were here earlier—\$740 million more in the system. I know that in 2004 the municipal sector specifically received about \$100 million more in their per diem in order to redress some historical problems that we had in the funding model.

Certainly we recognize that long-term care is a work in progress, and while this is legislation, we know that there are funding issues. We've heard from a lot of presenters, and I'll certainly make sure the Minister of Finance hears your point of view on this as we continue our budget deliberations.

I wanted to ask you a question on your compliance history. Belvedere has had a great compliance history, with very few "unmets" in the last few years. One of the things that we've talked about with some of our stakeholders is, how do we recognize good homes? Short of more money, which I know is going to be your first answer, are there ways that you, as the chair at Belvedere, would appreciate being recognized for running a great home in Parry Sound?

**Mr. Spadzinski:** I think the recognition that I find very rewarding is hearing at our monthly meetings some of the comments that family members make about the care of their parents, their relatives. I believe what we need to do is create a culture, and the culture that you create within a facility like Belvedere Heights has a lot to do with some intangibles. The intangibles that I believe make the difference in a long-term-care facility are staff knowing that they are appreciated, and the board being aware of the requirements and the needs and providing the tools to staff to take care of the things that they've been asked to do. It took Belvedere a little bit of time to develop that culture. We were actually in some difficulty in the late 1990s, and things have turned around dramatically. But I believe it's a culture.

I have to commend the province for addressing some of the issues that have been addressed in Bill 140. I may have been a little bit too off-handish or off the cuff in saying that it's hard to take those things seriously, but quite honestly, we are fighting a war now, waging a war, in a sense, over funding with our municipalities, and we haven't heard the last of it. I fired the opening salvo when I announced the 55% increase last Thursday night, and I can tell you that there's more coming.

**The Vice-Chair:** Mr. Ouellette?

**Mr. Ouellette:** Just a quick question: You mentioned that the level of funding needs to be stepped up, and we've regularly heard about the \$6,000 commitment. Do you think achieving that \$6,000 will satisfy the funding requirements?

**Mr. Spadzinski:** In our case, it won't. We're well beyond the \$6,000, but it will certainly help. We have some factors that we hope will be rectified, including an old building that isn't being utilized but that we still have to maintain. I can tell you that our municipal levy—I just did the rough calculations—is about \$12,000 over and above what we get from the residents and from the province per resident. And of the \$6,000 that was

promised, I think we have received about \$2,300. So an additional \$3,700 won't cover the total \$12,000 per resident per year, but I believe it will certainly make life a little easier for the board.

I believe the municipalities understand. They want to provide a good facility, and they're on board with us on that. But they are dealing with a lot of other issues, as you know, real problems with their infrastructure and the soft services. I always said, when I was the mayor of our municipality, that there are some things you just shouldn't pay for through property taxes because they don't fully recognize your ability to pay. I believe that some of the soft services that have been downloaded—I think municipalities are really stretched now to try to do all the things that we're requiring them to do.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you for your presentation. I appreciate you've said that even \$6,000 per resident is not going to get you over the hump. It might for some, so I'd like to see the government at least live up to that promise.

Let me follow up on you saying that that's not going to get you over the hump, because that's the current situation. The legislation, for example, mandates the licensee to ensure that the plan of care that's developed for each resident is provided. Then, in section 74, it talks about additional training to those staff who provide direct care. So you're going to have an obligation to provide increased training, especially around patients with dementia etc., all of which I agree with. You already have a serious financial problem that's not even going to be fixed if the government lives up to its promise. What are you going to do with the rest of this?

**Mr. Spadzinski:** As I said, we're in a very difficult bind. For example, we've talked about computerization. We are partially computerized, but even to find \$60,000 to complete that, and the staff training that goes along with that, is a stretch. So when you add additional requirements—and of course I listened to the last speaker. We can't do enough to take care of people who are so vulnerable and we want to do the very best. I believe that we're doing a great job in Parry Sound, but at the same time I'm at the point of frustration where I'm ready to resign. I have to tell you I'm not a quitter, but I almost feel overwhelmed. So when these new requirements come on board and there's no corresponding funding that's announced with it, it may come. I don't know, but the way things have been going, I'm a little suspicious about that.

1410

So here are these additional requirements, and we can't even meet the mandate now. That's why I'm saying it's very difficult for us to then take these new mandates seriously, the new requirements, when we haven't even been able to fulfill our current obligations without this incredible pressure that we're passing on to the municipalities. There are seven board members; two are provincial appointees and five are appointed by the area municipalities in the Parry Sound area. I can tell you that

we're going to be hard-pressed to find lay people who will serve on the board. Municipal councillors will come, but when they come, I can tell you there will be a different approach. They're not going to introduce 55% levy increases to their own councils. There's going to be a different approach.

I really appreciate the opportunity to speak to you and I wish you very well. Remember us out in the boonies, those of us who actually deliver the services to the seniors.

**The Vice-Chair:** Thank you very much for your presentation.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2368

**The Vice-Chair:** We'll move to our next presentation, which will be by the Canadian Union of Public Employees Local 2368. Welcome back again. You can start whenever you're ready.

**Mr. Leo Orford:** Good afternoon. Thank you for allowing me this time to present to you issues of concern regarding Bill 140. My name is Leo Orford. I'm president of CUPE Local 2368. With me are Maxine Middaugh, vice-president of CUPE Local 2368, and Brian Blakeley, research rep with CUPE Ontario. I am a personal support worker and have worked for the past 10 years at Manitoulin Lodge nursing home in Gore Bay.

I would like to start by congratulating the Liberal government on taking the initiative to address long-term care in this province. I believe that Bill 140 is a step in the right direction in consolidating three older pieces of legislation. However, if we are going to tackle the issue of long-term care, then let's make sure we completely address the issue and make this piece of legislation perfect.

Today I will address two areas of concern with this bill for my local and myself personally. Those two areas of concern are that Bill 140 does not address the need of a minimum standard of care, and also section 155, the appointment of an interim manager and the continuance of a collective agreement.

First, let me address the minimum standard of care.

CUPE Ontario has submitted to you in earlier briefs in Toronto a request for a standard of 3.5 hours, equal to the province of Alberta, and I support that proposal fully. A copy of this proposal is with my attachments. Let me explain why I support this recommendation by giving you a brief overview of my place of employment, Manitoulin Lodge nursing home.

Manitoulin Lodge nursing home is a 61-bed licensed and accredited facility with three additional beds: one short-stay and two respite. This facility is privately owned by Jarlette Health Services. This facility has both no-restraint and no-lift policies in place. Currently, this facility has an approximate 2.2-hour level of care per resident per day. Remember that this total includes not only care from the personal support workers, health care aides and nurse aides but also from the registered nurses



and registered practical nurses. I have provided in my summary a breakdown that shows the calculations and allotment of these hours of care per 24-hour period per shift.

From these hours of care per resident per day, my membership must care for these 64 people. I use the word "people" because I want you to remember that when we refer to residents in long-term-care facilities, we are speaking about real people. Out of these 64 people, 92% suffer from some form of cognitive impairment, be it psychiatric or dementia-related. Out of these 64 people, only four do not suffer from some form of incontinence. With ambulation and transferring, 30 of these 64 people are wheelchair-bound or -dependent. Twelve of the remaining 34 people are dependent on walkers or canes and require staff assistance or supervision with mobility. Five of the remaining 22 people require staff assistance with ambulation. Of the 17 remaining people, only three do not suffer from an unsteady gait. For transferring, there are nine that require a mechanical lift and 14 that require a two-person transfer.

With activities of daily living, 55 of these people require total care with washing and dressing. Of the other nine, five require constant assistance from staff in washing and dressing and four require minimal assistance. With feeding and meal consumption, there are 13 who are complete feedings and 15 who are constant encouragement and assistance. These are just some of the facts that I thought might help paint a picture for the members of this committee as to the care levels that currently exist within nursing homes.

Also in my submission, I included a copy of the duty guidelines for Manitoulin Lodge to help give a breakdown of how care tasks are distributed or assigned. If you review these guidelines, you will note that this is a very time-regimented process and that it leaves no room for unusual occurrences. Let me explain in a little more detail what I mean by unusual occurrences. This can entail, but is not limited to, explosive diarrhea, vomiting, excessive behaviours or aggression, illness, palliative care measures, falls and injuries etc.

I am sorry, but with limited time and hands-on care, the people are impacted and their quality of life suffers the consequences. I am sorry, but promotion of self-sufficiency is overlooked because, for example, a caregiver can wash a person's hands and face faster than letting the individual do the task, and then touch it up if they did not do a good job. I am sorry, but episodes of incontinence are not avoided because a caregiver cannot be at two places at once and cannot attend to the toileting requests of four or five people all at the same time. I am sorry, but residents' choices are reduced because staff do not have the time to search through a closet if the first choice of clothing provided is not satisfactory to the resident. I am sorry, but residents must wait for their needs to be met, which can lead to an increase in behaviours, which in turn leads to an increased workload. I am sorry, but an increase in staff workload can lead to an increase in staff stress levels, which impacts on our

care and ultimately impacts on the people we are caring for. I am sorry, but without the hours and staffing, charting and documentation are placed second to care. Thus, behaviours go undocumented or just become accepted as the norm for that individual, effectively resulting in a loss of funding. I am sorry, but without more time and staff, standards will go unmet. Currently, it is now a task to get our people to breakfast on time or have an extra minute to encourage fluid intake so the 48-ounce fluid standard is met.

This is a vicious cycle, because if we do not meet standards and complete the documentation, our funding is affected and, ultimately, the hands-on care is affected or reduced and the workload becomes more impossible. A minimum standard of care, as suggested by CUPE Ontario, of 3.5 hours would help to resolve this cycle and provide the front-line staff with the extra time that is needed to give the people that little extra and make their lives a little more enjoyable.

Please remember that the people of Ontario's long-term-care facilities helped make this province what it is, so let us make this piece of legislation what it needs to be. Address the issue of a minimum standard of care and give these people the care and respect they deserve. For myself, I hope that it is a while before I need the services of Ontario's long-term-care sector, but for some on this committee and for a lot of this province's voters, it is a reality of the near future. Please consider this as you contemplate this piece of legislation.

Now let me address my second concern: section 155. This section deals with the interim manager appointments under section 154 of this bill. Currently, this section of the bill will lead to labour relations instability and ultimately impact resident care. If an interim manager is appointed, then I see no reason why the employees' current collective agreement could not and should not stay binding. If the faults leading up to the appointment of an interim manager lie with the owner, why should the employee suffer? Therefore, I and my local support CUPE Ontario's submission that Bill 140 should be amended to provide for as little disturbance or disruption as possible when an interim manager is appointed by deleting subsections 155(7) and (9).

Thank you again for allowing me this time to present on Bill 140. I again ask that you consider the submissions you hear at these limited public hearings before finalizing this piece of legislation. This bill has the potential to truly address and fix long-term care in this province. All this committee needs to do is listen to the people, listen to the caregivers, listen to the families, and listen to the people within the long-term-care sector who know first-hand what this bill needs to be perfect.

**The Vice-Chair:** Thank you very much for your presentation. We have three minutes left. We can start with Mr. Ouellette.

1420

**Mr. Ouellette:** Just a quick question: You mentioned that you had a no-restraint, no-lift policy in place, yet on the next page you mention that nine require mechanical lifts and 14 require two-person transfers.

**Mr. Orford:** Yes, a two-person transfer not in lifting but in stabilizing the transfer so that they don't—

**The Vice-Chair:** Would you mind getting closer to the microphone?

**Mr. Orford:** It's to stabilize them and make sure that they don't fall. They still are able to weight-bear, it's just that they need a slight lift. Someone who cannot weight-bear we're not lifting entirely with our body. We have machines for that.

**Mr. Ouellette:** Okay. Thank you.

**Ms. Martel:** Thank you for your presentation. I want to focus on section 155. I think I understand what you want in subsection 155(7). If I read it correctly, there shouldn't be any changes to the terms and conditions, even if there is an interim manager. If a collective agreement is in place, everything should stay the same.

**Mr. Orford:** Yes.

**Ms. Martel:** Okay, I get that one. It's subsection 155(9) I'm not quite certain about. Do you mean, then, that if there is a change, it should be considered a sale of business so that successor rights apply? I apologize if I'm getting this wrong.

**Mr. Orford:** I'll refer this to Brian.

**Mr. Blakeley:** Ms. Martel, it is handled as a sale of business and we have no problem with that. The problem we have is that currently during the period of time of the interim manager's presence, the collective agreement is not continued by legislation; in fact, it's stopped. So we would ask that the act be amended so that the collective agreement continues to apply. We note and we're pleased to see that the act provides some financial security to employees of the departed, if I can say that, employer. We'd just like to see these two sections dealt with so that the collective agreement applies, the sale of business would carry through, and people wouldn't suffer because of the conduct of their previous employer.

**The Vice-Chair:** Ms. Smith?

**Ms. Smith:** Just to clarify, though, after an interim manager, if someone else is coming in, then that transfer is considered a sale of business and everything applies yet again. So it's just for that short period of time where there may be an interim manager in place, and even in that situation, we have made provisions in the legislation so that the financial implications that could result are covered off by the government or the interim manager.

**Mr. Blakeley:** Yes, and we believe that what we're asking for is a very minor adjustment. The reality of our experience is that in most cases the collective agreements are de facto continued; they're just not legally binding. It seems to be a relatively minor change that we think is a good step to protect people's rights.

**Ms. Smith:** Just to follow up on Mr. Ouellette's point, the "no lifts" is no physical lifts; you can use mechanical lifts. Is that right?

**Mr. Orford:** Yes.

**Ms. Smith:** Okay. And your 2.2 hours of care—this is the calculation that you have attached?

**Mr. Orford:** Yes.

**Ms. Smith:** And that's what's happening presently at your home on Manitoulin. So you're including in that number the RN, the RPN—sorry, in some places it says "RN" and in some places it says "day shift." Those are personal support workers or health care aides?

**Mr. Orford:** Yes. That's off to the side in pen. I put "PSW" and "health care aide." Sorry.

**Ms. Smith:** Okay. That's great. Thank you very much.

**The Vice-Chair:** Thank you very much for your presentation.

DAVID CHESLOCK

CATHY LABRASH

**The Vice-Chair:** I believe the District Municipality of Muskoka is not here. Are they here? No. So we are going to move to the following presentation, by David Cheslock. Is he here? Okay. Welcome to the standing committee on social policy. You can start whenever you're ready. You have 15 minutes. You can divide it between presentation and questions.

**Mr. David Cheslock:** First of all, thank you to the Chair and the members of the committee for allowing us to make a presentation to you today. My name is David Cheslock. I'm a registered practical nurse with over 13 years in the long-term-care industry. Joining me today is Cathy Labrash, also a registered practical nurse, with over 15 years of service in long-term care. I'm a former employee of Extendicare Falconbridge and Ms. Labrash is currently employed in a full-time position at Extendicare Falconbridge in Sudbury.

We're here today to raise our concerns regarding the new Long-Term Care Homes Act, as it has been proposed, and its effects on resident care. It seems that only a few short years ago Mr. Smitherman promised us a revolution in the long-term-care industry and proposed to fix the problems that plagued this industry for over a decade.

In a response to a Local 204 SEIU questionnaire that was sent out on June 11, 2003, Mr. McGuinty's government promised to reinstate the minimum-hours-of-care standard that was removed by the Harris government. This included 2.25 hours of nursing care daily. Furthermore, they promised they would instate a three-baths-per-week standard. The reality is that we have seen no standard of three baths; instead, we have seen two baths. And we have seen no standard hours of care. My question is, what happened?

The staff who care for our family members every day in long-term-care homes used to pour their hearts into providing this care and they used to be a surrogate family, filling in for us when we were not there due to our work and other obligations. I say they used to, because with the increasing workloads caused by government regulations and more medically complex cases, the staff have simply run out of time.

In regard to the bathing issue, let me say that what I learned in school was that three does not equal two.



Giving every resident two baths per week is a great improvement, but it is definitely not three. The only problem with the two baths is that there was no increase in the staffing to accommodate the change in workload. At Extendicare Falconbridge in Sudbury, they put in the two baths without any increase to the number of care hours being provided. This means that the same number of staff must now give approximately 234 additional baths every week. My mother always said that I would never be an accountant and that I'd never be a mathematician, but I know bad math when I see it, and that is bad math.

I think when we discuss hours of care, there is often a misconception of what that actually means to a resident's life. If we look at the hours of care at Extendicare Falconbridge, based on SEIU calculations, there was an average 2.12 hours of care per resident per day. When you take RNs into consideration and realize that they typically do not provide hands-on care and you take them out of that equation, it reduces it to 1.93. It sounds like a lot of hours—1.93 hours per resident per day. However, when you look at it in reality, what does the number really mean?

Let me point out a few things that no one takes into consideration when looking at hours of care. Of that 1.93 hours there are tasks that need to be performed that do not provide direct interaction with a resident. For a PSW, this will include 20 to 30 minutes of charting each and every shift that must be done. This used to be much shorter, but over the years government regulations designed to ensure proper resident care increased the amount of charting required. Other tasks include loading linen and supply carts to take to your rooms on your rounds, cleaning every piece of equipment that you need to perform your duties, and for infection-control purposes, frequently cleaning them in between each resident.

It includes putting away personal laundry, cleaning bedside tables, dressers and closets. It includes checking every item in a room to ensure that a resident's name is properly identified on each and every item; serving dinner plates at all meals, including beverages; hauling away dirty laundry; in-servicing to ensure people are properly educated and updated on all aspects of their duties; serving refreshments three times a day; and let's not forget, going room to room to get equipment. Walking actually takes a lot of time in some of these big buildings. All of these things cut into the time of the 1.93 hours.

Let us not forget that the RPN role is critical to care of the client as well, but they surely spend much less time with a resident than the PSW does. Much of their time is spent preparing medication for the resident, as it usually takes more time to prepare than it does to actually administer that medication. An RPN can take on average two and a half to three hours for morning medications, one to two hours for noon medications, one to two hours at dinnertime for medications and another three hours for bedtime medications. This does not include what are called PRN medications—as-needed medications—such as analgesics for pain.

An RPN must further chart all PRN medication given. This means that a simple Tylenol can take up to five minutes to prepare and chart, not including the time to actually administer that medication. Charting can take several hours each shift when you include the charting for PRNs, resident quarterly reviews, doctor orders, signing in medication from pharmacies and other tasks.

I could spend an hour just running on about those individual things that cut into that time. We should also consider that RPNs must address family concerns and answer repeated phone calls to the units. None of these tasks provide interaction with a resident, but they all become part of that 1.93 hours.

**1430**

Based on this information, I think it is fair to say that hands-on care can actually be measured in minutes, not hours. I am not saying the tasks are not important; I'm not saying they don't have their place. However, they do not provide hands-on, human interaction, the missing component of the formula for quality resident care. I could bore you with a lot of numbers and studies that show that Ontario is at the bottom end of the care hours, but I'm sure you all know these numbers already. I ask the government to reinstate the standard hours of care into the act and increase it to 3.5 hours, thus bringing Ontario in line with the rest of North America. Ontario residents deserve better.

**Ms. Cathy Labrash:** Thank you for allowing me the opportunity to speak to you today. I would like to address the staffing issues challenging the long-term-care industry.

Almost every day that staff report to work, one of the shifts is working short-staffed. The shortage of staff is a result of the employees leaving the industry to go to hospitals, where the workload is substantially decreased and the wages are much higher. This makes it nearly impossible to recruit and retain staff.

Allow me to provide some examples of recent events at Extendicare. Saturday, I was asked to work a double shift. Sunday, I received the same request. No sooner had I arrived at home than I received a phone call asking me to come back to work a night shift as a responsible RPN. "Responsible" means there is no RN available to work the shift, and the RPN assumes the responsibilities in his or her place. This means that there is no RN in the facility on that particular night.

The employer's response to a situation like this is an on-call list. If I need a medical directive for a resident who may be having pain, I must call the manager who is on call. This does not allow for proper coverage during an emergency situation. The employer is increasing the training for RPNs who are willing to work as a responsible person. How does this address the fact that there is still frequently no RN in our facility?

To further the problem, if no one is willing to come into work and the RPNs are already working short that night, they are told that they are responsible for their own floors. This reduces the number of professional staff in a building from the regular four to three. One can only

hope that we are not already working short on one of those floors—RPN or PSWs.

The best-case scenario is that all staff show up on a night shift and we have 10 people in our building to spread over our three floors. What will happen should there be a large-scale emergency in this facility?

The staffing in general in our facility has reached critical proportions. We continually work short, which ultimately impacts our residents. The only way to address the shortage is to address our workloads and the hours of care. No staff member wants to go to work and tell a resident that they don't have time to assist with some task of daily living, but what is the choice? Telling a resident that you do not have time right now is a totally unacceptable response.

There are insufficient people to provide care as mandated by the Ministry of Health and Long-Term Care. The employer regularly reminds staff that work has to get done even if we're working short. The employers have developed staffing plans, frequently called "plan Bs," which is one staff member short on a unit, and sometimes we've been "plan C," which is two staff members short on a unit. When all else fails, they'll tell us to pass it on to the next shift. The question is, where does this overflow ever get picked up? The other shift is already running to capacity and often they are working short as well.

Regardless if it is a PSW, an RPN or an RN, the end result is that we are working short. It seems to be a never-ending circle. The real surprise occurs when staff come to work and find out we are actually working full-staffed.

Insufficient staffing puts residents' safety at risk. Even at full staffing levels, there are not enough bodies to monitor the residents. On my unit there are nine PSWs, two RPNs and one RN on a day shift. There are approximately 78 residents with numerous health and care issues. Although it looks good on paper, the truth is that we are constantly pulled away from resident care for many different reasons, such as:

- in-servicing, which reduces staffing to half. These in-services are usually held for 15 to 30 minutes and occur before a break. This means that half the staff could possibly be off our unit for the better part of an hour. Most of this in-servicing is mandated under the Ministry of Health standards; and

- professional staff meetings. These meetings take all our professional staff off all units for approximately one hour, give or take 15 minutes.

The level of burnout among long-term-care staff is increasing every day. The staff are emotionally drained by the demands put on them by all parties. Residents are not blind to human emotion and easily detect the tension and fatigue of the staff. This does not lend itself to a therapeutic relationship. Ultimately, staff pays the final price for the stresses by injuring themselves trying to get an unreasonable workload completed. The end result is another short-staff situation that will result in lower resident care.

The most recent demand on staff has come as a result of the MDS program developed by the Ministry of Health

and Long-Term Care. This program alone has increased the amount of work required from every RPN in the facility. An annual assessment on a typical resident under the program will take an average of 30 minutes. The follow-up documentation required by this program can increase the charting on every RPN by several hours a week. The staff find it difficult to meet the deadlines in this program due to existing workloads, as evidenced by frequent reminders by RAI co-ordinators that assessments are due.

These are some of the challenges we face in regard to staffing levels.

I would like to thank the committee for allowing us to present to you today.

**The Vice-Chair:** Thank you very much for your presentation. We have two minutes left, which gives every party a chance for a quick question or comment. Ms. Martel.

**Ms. Martel:** Thank you, both of you, for being here today. Double shift: Does that become 12 hours?

**Ms. Labrash:** It's 16.

**Ms. Martel:** So, Saturday, 16; Sunday, 16. You got home and were called in for Sunday night to come in for a night shift?

**Ms. Labrash:** Had I accepted the shifts, it would have been a 16-hour shift on Saturday and a 16-hour shift on Sunday as well.

**Ms. Martel:** How often is there no RN in the home at night?

**Ms. Labrash:** I'm not really sure of the numbers, but it's quite frequent.

**Ms. Martel:** How often are you working short-staffed? Is that being monitored by the union at all, for example?

**Ms. Labrash:** Yes, it's reported to the union when we are working short, and we just keep track of it.

**Ms. Martel:** Do you have any idea, let's say, in the last six months, what those numbers might be? Sorry to catch you off guard. I'm just curious.

**Mr. Cheslock:** About 20 times every month, they're running staff-short.

**Ms. Martel:** And you're also monitoring if that's one short or two short? Should I assume that's usually one?

**Mr. Cheslock:** We are monitoring it, and we can pull it. You shouldn't assume it's one. Sometimes it's two. Sometimes it's one on every unit. Sometimes it's up to two per unit. So it's not uncommon.

**The Vice-Chair:** Parliamentary assistant?

**Ms. Smith:** Thank you for being here. When you don't have a 24/7 RN, has that been reported to the ministry? Because there is a regulatory requirement now for 24/7 RNs in our homes.

**Ms. Labrash:** I'm not sure if it has been.

**Ms. Smith:** I wanted to ask you, when you did your calculations about the number of hours—and then I think you factored out the RN. We had other presenters factor out RPNs for the minimum standard number. We've had a variety of opinions on what should be included in the minimum standard number. I'd be interested to hear



which caregivers in the home you think should be included in the minimum standard number.

**Mr. Cheslock:** I believe it should include anyone who provides actual hands-on care or interaction with a resident. So we would say that would include RPNs, PSWs, and it could potentially include RNs, depending on the job description of that individual. It shouldn't include an RN who is a supervisor rather than an actual hands-on care provider.

**Ms. Smith:** Would you include in that number any of the activation people, the activities coordinators, the people who deal more in the secure units with those suffering from dementia, who may not have actual physical demands but may need more redirection and help—sundowning?

**Mr. Cheslock:** In the facility we were looking at, which is the one we come from, there is no one in that capacity. The activation department doesn't provide that type of care. They provide actual activities. So I would say, in that case, no.

**The Vice-Chair:** Thank you very much for your presentation.

The next presentation will be by the city of Greater Sudbury. I believe they're not here yet. Is anybody here from the city of Sudbury? We'll recess until 3 o'clock.

*The committee recessed from 1440 to 1441.*

#### CITY OF GREATER SUDBURY

**The Vice-Chair:** If it's okay with all members, the mayor of Sudbury is here, so we can start anytime. It's okay with you? From the city of Greater Sudbury we have a councillor with us, the deputy mayor.

**Mr. Ron Dupuis:** Good afternoon.

**The Vice-Chair:** Good afternoon. You can start whenever you're relaxed and ready.

**Mr. Dupuis:** We will be having Randy Hotta, who is the director of our city-owned facility.

As stated, my name is Ron Dupuis. I'm a deputy mayor with the city of Greater Sudbury. For the past six years, I have also represented city council on the management board of Pioneer Manor, which is a municipally owned and operated facility. As a sidebar, I just want you to know that both of my parents live at Pioneer Manor.

First and foremost, it's important that I thank the standing committee on social policy for allowing us this opportunity that ensures that Bill 140, the Long-Term Care Homes Act, 2006, will be amended so that it ensures that all residents who access accommodations and care in these facilities not only remain the focus of this proposed bill, but that long-term-care facilities will be accountable in a way that is realistic.

The city of Greater Sudbury, as you've probably heard today, has six long-term-care facilities with a total of 1,218 long-term-care beds. Due to the bed shortages in our acute-care system, there have been an additional 72 interim beds added. Of those 72, 70 are currently being managed by Pioneer Manor.

The demographics of our community critically indicate that the city of Greater Sudbury has a rapidly growing elderly population and that more and more older adults, seniors, will eventually require the care and services of a long-term-care facility. The Ministry of Health and Long-Term Care has recognized the needs of our community and has included Greater Sudbury in its recent call for applications for an additional 96 long-term-care beds that will then bring our long-term-care-bed capacity to over 1,300.

Since 1953, Pioneer Manor has been owned and operated by the city of Greater Sudbury. I am proud to say that for the past 53 years our facility has not only been home to thousands of residents, but it has been recognized as the facility of choice for many within our community. As well, for those 53 years the home has been financially operated in a very responsible and accountable manner.

Pioneer Manor is a member of the Ontario Long Term Care Association. Therefore, we strongly echo and support the amendments that they have brought forward to the standing committee on social policy. The city of Greater Sudbury is also a member of the Association of Municipalities of Ontario, and they have recommended amendments that are critical in ensuring that municipally owned and operated homes are recognized for their already significant contribution and accountability to their respective communities.

I recognize that there are a number of amendments that need to be made to Bill 140, but as the owner-operator of a municipally owned home for the aged long-term-care facility, the following issues are recognized by our board of management as having the most significant impact on our operations.

The first one of those is the duties of directors and officers of a corporation. Accountability is foremost the responsibility of any board of management. There is a need to ensure that those individuals in such a position remain credible and must answer to those who have put them in a position of trust. Municipally owned and operated facilities entrust their council members to this task. Section 67 certainly implies the need for accountability, but to an extreme that makes it unattractive to get involved on a board of directors or board of management and places a community in a very vulnerable position. Council members welcome the commitment they've made to represent their community on numerous boards, but we do so in a position where we feel we can make a significant contribution and in a manner of trust. If every board imposed the same penalty as is being proposed in Bill 140, many corporations would not recruit credible individuals. A board's role is to provide direction at the micro level and to make policy decisions. It is not their role to be involved in the day-to-day administration and operation of the homes. The board's role is to ensure the homes are well managed, not to manage them directly.

Licensing: In 2005, Pioneer Manor successfully completed a \$22-million redevelopment plan whereby half of this 342-bed facility now meets the A standards. There

remain 154 beds which do not meet the new provincial standards but, according to this proposed bill, the ministry has the authority to enforce the upgrading of the facility as a condition of renewing their licence. The concern is not the fact that we should be ensuring that we provide residents with the accommodations and a lifestyle they deserve, but funding needs to be addressed in Bill 140 prior to the ministry's enforcement of such a matter.

As you're probably aware, on October 26, 2006, Pioneer Manor was the victim of an unfortunate fire that not only caused significant damage, but it also stripped 20 residents of their homes, and they lost the few cherished valuables that they owned. I hope that this bill will also recognize unfortunate incidents such as this and ensure that any restructuring that needs to take place will be done in a way that will only make a bad situation better.

Regarding funding, the city of Greater Sudbury is a proud owner of a home for the aged. We are very concerned that, through this proposed bill, the province of Ontario is trying to get municipalities out of the business of operating long-term-care facilities. History has it that when homes for the aged were legislated to become long-term-care facilities, we faced a massive challenge to our daily operations. The dynamics of the level of care changed dramatically, making it necessary for municipalities to conform. The challenge was not in the need to change the way we did business, but in the way we had to secure funding in order to make this happen. With any new standards that the ministry imposes there needs to be adequate funding to ensure that the systems can be put into place without any disruption to the residents. Therefore, I cannot stress enough that adequate funding is the only way that we can ensure that the new standards are complied with.

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Another matter that is worth mentioning is the per diem for raw food. Residents of long-term-care facilities receive \$5.46 per diem, while prisoners receive more than twice that amount.

As I have indicated before, there are many other amendments that we do support. As the city of Greater Sudbury council stated in its motion that was passed unanimously on January 17, 2007:

"Therefore, be it resolved that the city of Greater Sudbury supports the need to ensure that submissions being presented to the standing committee be reviewed for consideration and whereby the proposed amendments will ensure that the purpose of Bill 140—Long-Term Care Homes Act, 2006—will improve people's quality of life and protect residents in long-term-care homes; and

"That there be sufficient operating and capital funds for homes to meet the requirements and standards of the proposed legislation."

An effective and accountable Bill 140, the Long-Term Care Homes Act, 2006, should be a piece of legislation that will allow us—owner-operators, residents, families and staff—to work together at ensuring that the care, services and support we offer to residents be world-class,

so that through this whole process we remember whom this bill is intended to protect and serve and that the end result will be one that will benefit our residents, who are our mothers, fathers, grandmothers, grandfathers—anyone we love. Thank you very much.

**The Vice-Chair:** Thank you very much for your presentation. We have five minutes left. We can give almost two minutes to each party. Parliamentary assistant?

**Ms. Smith:** Thank you for being here today and providing us with some insight into Pioneer Manor. We did hear a little bit about some of the programming that you have there through the Alzheimer Society this morning, which was very helpful.

I, first of all, wanted to just clarify on the food issue. There's a big myth out there that keeps getting propagated about the food. In fact, the number that is put out about inmates is the prepared food cost of \$11.43 versus the raw food cost of \$5.46 which we have in long-term care. Our prepared food cost is actually \$18.10. So if you're going to compare apples to apples, we are actually investing more in our food preparation than they do in our prisons.

You talked about the renewal of licensing. Pioneer Manor is, I understand, a municipal home, and you don't fall under the licensing scheme in the legislation; you are an approved home. Isn't that correct?

**Mr. Randy Hotta:** That's correct, yes. But in the act, is that going to change?

**Ms. Smith:** No.

**Mr. Hotta:** Municipal homes will not be affected the same way?

**Ms. Smith:** In municipal homes, we are continuing the status quo of approvals, yes. There won't be a licence or a licence term on municipal homes. So I just wanted to clarify that.

Also, when you talked about a change in funding, I did note that in 2004, when the McGuinty government put a large influx of funding into long-term care, one of the sectors that we invested about \$100 million in was the municipal sector, and that was in order to redress the historical anomaly that had existed for some time. We heard a lot from your association on that point, so I just wanted to note that that investment was made in order to assist the homes, and in that year the increase in your per diem was quite a bit higher than the rest of the sector.

I want to thank you, though, for coming today and providing us with your input, and I look forward to continuing to work with you in providing long-term care in Sudbury.

**The Vice-Chair:** Thank you very much. Mr. Ouellette, I guess, is going to get one minute extra because I missed him the last time. My apologies.

**Mr. Ouellette:** Thanks for your presentation. First of all, in light of yesterday's headlines in the Sudbury Star, it's good to see that the local council is getting involved in trying to resolve a lot of these health care issues, although I was a bit concerned with the way it was reported in the paper about the response and how you're



working together. Can you give us any insight as to how the ministry is working positively with you to resolve some of these issues, or are you working directly on that? Do you know?

**Mr. Dupuis:** That is not part of my portfolio, but I have to be quite honest with you that when it comes to the local newspaper, I just don't read it.

**Mr. Ouellette:** That's fine. We heard from another individual on council who reported to his council last Thursday that they are going to receive a 55% increase in their municipal contribution to municipal facilities. Are you seeing that sort of response, or locally here in the Sudbury area?

**Mr. Hotta:** No.

**Mr. Dupuis:** Randy tells me no, but all in all, I think, if we look at what has been happening as far as health care in our area, there's a lot of frustration out there with our hospital and the slow movement on that, but it's something that is certainly being addressed. We're so looking forward to seeing that project completed.

**Mr. Ouellette:** You mentioned the capital funding requirements. On average, what would you expect that the funding levels would need to be as a percentage of the operation in order to maintain the level that's going to be expected for the facilities locally?

**Mr. Dupuis:** I'll refer that to Randy.

**Mr. Hotta:** I think the answer is that when you look at the legislation, for example in your type of question, what happens, to give you a real example, is that when compliance comes to a home and they order you to—for the sake of the argument, get mag locks and keypads. Correct? So we look at the costs. In this case it was \$35,000. In order to comply with the Ministry of Health, the standard is that we require it because it's an older part of the building, so this money has to come from somewhere. Usually we have to find the money within the budget. We call the program people and they have no money.

These are just practical questions that we have to deal with on a day-to-day basis. In essence, with the capital side, whether it be renovations or anything, we have to do it ourselves. Unless someone else can tell me differently, there are other monies available for capital funding. I know that we're trying to get our B and C beds upgraded at the same time as well. There's a concern that if we don't keep the beds upgraded, compliance would come in and say, "They don't meet the standards." So we're caught somewhere between a rock and a hard place in those situations.

**Mr. Ouellette:** Thank you. Those are all the questions I have.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for being here today. The story, Ron, was about Sudbury's ongoing crisis with

alternate-level-of-care patients. It has gone on for three years now. The council is well aware of it, and so is Mr. Hotta, because he has been trying to cope with it at Pioneer Manor. Can you tell me: What's the top-up—I'm assuming there is; maybe there isn't—that the municipality provides to Pioneer Manor for operations?

**Mr. Hotta:** It's about 4% of our budget.

**Ms. Martel:** Can you give that to me in dollars, please, Randy?

**Mr. Hotta:** In dollars, in real program dollars, I would say around \$963,000.

**Ms. Martel:** What does that go into? Is that paying for additional staff?

**Mr. Hotta:** It pays for any overruns from the provincial dollars that we have in the budget. So it covers other costs beyond our budget.

**Ms. Martel:** Would the overruns usually relate to—

**Mr. Hotta:** For example, nursing.

**Ms. Martel:** Okay. I have two. So care—nursing: What about PSWs, RPNs?

**Mr. Hotta:** It's all the same group.

**Ms. Martel:** All of the above?

**Mr. Hotta:** Yes.

**Ms. Martel:** What portion of that \$900,000 would then be directed to staff? You are trying to have the staff you need to meet residents' needs.

**Mr. Hotta:** Probably, in our budget, most of it, 90% of it, would be front-line staff.

**Ms. Martel:** Is that \$900,000 plus an increase over the last couple of years? Can you respond to that?

**Mr. Hotta:** I think it has been pretty close to that amount. It went up a bit last year. We're one of the lowest, I believe, in the province on a per diem basis from municipal contributions.

**Ms. Martel:** In terms of the requirements in the bill, because the bill says you should have to meet the level-of-care plan that's set out for every resident, that you should provide the extra training that's required, all of which I don't disagree with, do you have any sense of where the money is going to come from to allow you to do that?

**Mr. Hotta:** It either comes from the user fees or it comes from the province, and that's going to be difficult right now.

**Ms. Martel:** Because the municipal contribution is already over \$900,000 to cover a shortfall?

**Mr. Hotta:** That's right. And if we raise it, then we have to go back to council, and there are issues regarding using property tax money more and more for that type of purpose.

**The Vice-Chair:** Thank you very much.

We're going to adjourn until tomorrow at 9 o'clock. I believe we'll be in London at the Four Points Sheraton.

*The committee adjourned at 1459.*











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## Legislative Assembly of Ontario

Second Session, 38<sup>th</sup> Parliament

## Assemblée législative de l'Ontario

Deuxième session, 38<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 24 January 2007

# Journal des débats (Hansard)

Mercredi 24 janvier 2007

**Standing committee on  
social policy**

Long-Term Care  
Homes Act, 2007

**Comité permanent de  
la politique sociale**

Loi de 2007 sur les foyers de  
soins de longue durée



Chair: Ernie Parsons  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Wednesday 24 January 2007

Mercredi 24 janvier 2007

*The committee met at 0904 in the Four Points by Sheraton Hotel, London.*

LONG-TERM CARE HOMES ACT, 2007  
LOI DE 2007 SUR LES FOYERS DE SOINS  
DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

**The Chair (Mr. Ernie Parsons):** Good morning. I would like to call the meeting to order. Welcome to the standing committee on social policy, here to receive input from you on Bill 140, An Act respecting long-term care homes.

Just as a general announcement, each presentation will have 15 minutes. You're free to speak for up to the 15 minutes, but if you stop prior to that, it will provide an opportunity for questions from all three parties, which will rotate, and the question time will be distributed evenly between the three.

## OXFORD HEALTH COALITION

**The Chair:** The first presentation registered is Oxford Health Coalition.

Welcome. If you would come forward. I would ask that when you come forward, you state your name to enter it into Hansard.

**Mr. Shawn Rouse:** Good morning. My name is Shawn Rouse and I am here as a representative of the Oxford Health Coalition.

**Ms. Janice Courtney:** My name is Janice Courtney and I am here as a family member from Oxford.

**Mr. Rouse:** Good morning, distinguished Chair and honourable members of the standing committee on social policy. My thanks to the committee for this opportunity to speak on Bill 140, An Act respecting long-term care homes. As I said, my name is Shawn Rouse and I am a chairperson of the Oxford Health Coalition. I know that many groups and individuals have requested standing here today, and I will do my best to present a submission that is reflective of the concerns that are front and centre here in Oxford county of long-term-care front-line staff, residents, and community.

The drafting of this act has been a good first step. The inclusion of the residents' bill of rights, the proposed

intent to limit casual and agency staff, the increased powers of inspectors and continuing surprise inspections are all very good new initiatives. They are indicative of a real willingness to change for the better and not just change for change's sake.

Where the act does fail the residents and their families is in what is missing in the act. What we see as a root issue in many of the continuing problems plaguing resident care is the missing language surrounding a minimum care standard. An interesting issue has arisen in the presentation of an actual regulation reported on the long-term-care website that speaks to a minimum requirement for staffing levels in the dietary department of 0.42 hours per resident meal day. There is a formula to amend the number if the dietary department is shared with a retirement home or a hospital. Imagine that there are no minimum staffing levels in nursing, but there are in dietary. Compliance staff will be enforcing this and may request staffing schedules, records of resident meal days and duty rosters, among other things. Dietary standards are outlined in seven pages, and nursing standards are outlined in four.

We are insisting that the key component is the re-installation of a minimum care standard. We recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours of nursing and personal care per day per resident. This is to reach the goal of prevention of risk; it is not an optimum. The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers. This is a defined number of hours of care that is attached to a particular level of assessed need. We are proposing that Ontario adopt a 3.5-hour minimum care standard of hands-on care. This means that a facility with the average case mix would receive resources for nursing and personal support care specifically to provide 3.5 hours of personal care per resident. Those facilities with lower acuity levels would receive less; those with higher acuity levels would receive more.

In 1996, the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. Since then, care levels have dropped below the previous standard. Since then, the average acuity of

residents in long-term care has increased dramatically. We are insisting that the government reinstate a care standard to improve the quality of life in long-term-care homes. Since the level of acuity has increased with the downloading of heavier-care patients from hospitals and mental health facilities and with the aging of residents, the standard must be modernized to meet today's care needs

0910

Based on research of standards in other jurisdictions across Canada and the US, we believe that 3.5 hours of care would be the minimum required to reach the goal of prevention of risk. This does not, as Minister Smitherman was saying the other day, promote assembly line care; this prevents it from continuing. This brings dignity back to the care of our parents and grandparents. This should be adopted as an interim measure while the government undertakes the research necessary to define the care levels associated with the current assessed levels of need.

I have received many first-hand reports from front-line staff in some of our largest long-term-care facilities in Oxford. Staff routinely give more than eight hours' work per day. They miss their breaks and lunches, they come in early and they stay late to ensure that the residents are provided with proper care. These people come in on their days off and visit with residents' families. They pick up residents' spouses who no longer have the ability to drive so that they may visit with their life partner.

In 1995 and 2002, the Provincial Auditor noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor has criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PricewaterhouseCoopers report, and inadequate tracking of contagious disease outbreaks. In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. The ministry has never updated, nor has it addressed, the findings of the 2001 PricewaterhouseCoopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs, including depression, cognitive impairment and behavioural problems.

The government uses an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool in 70 long-term-care homes. The tool allows facilities and the government to determine the case mix. The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity and those with heavier needs are deemed to have higher acuity.

However, there is no expected amount of care that is attached to the average level of acuity. An array of reports, media exposés, and testimony of families and care staff have shown that there are serious inadequacies

in care provision. In Oxford, there has been a pandemic of direct front-line care hours being reduced by management in the past year. There is not enough staff to provide the needed care.

Staff are unable to get their care work done to expected standards within the time they have on their shifts. Bathing, repositioning, referrals to medical care and even feeding are left undone because there is not enough care time. This results in residents being transferred to acute care through emergency departments. This shortfall has serious health and quality-of-life implications for residents and staff, and results in increased injuries to staff as well as to the residents. Some staff have reported that four minutes to wake and dress a resident is the norm. If the resident is not able to help, then sometimes two staff are needed. This takes time away from other residents, and some end up losing their personal care. A loss in care one day cannot be made up the next day without further penalties on those residents. All of this wears very heavily on the staff and especially on the residents. Some residents who have lost their ability to speak lash out physically. Documented cases of staff abuse by residents are almost a regular occurrence.

A care standard would set an expected level of care, weighted by the assessed acuity of the resident. This would provide one of the most important tools in assessment of appropriate funding and provide greatly improved opportunities for accountability.

What does the research show about minimum care standards?

—The province of Alberta has set a policy direction to bring care to 3.6 hours, and funding is at 3.6 hours as of the latest budget.

—The Liberal Party of New Brunswick recently won an election with a pledge to phase in a minimum standard of 3.5 hours by 2008.

—Nova Scotia is increasing its previous 2.25-hour guideline to 3.25 hours.

—PricewaterhouseCoopers found that Saskatchewan was at 3.1 hours in 2001.

—Thirty-seven US states have established minimum staffing standards either in statute or in regulation. While Ontario dumped its care standard, 13 US states increased their staffing standards between 1999 and 2001.

—The US Health Care Financing Administration conducted major research to deliver two phases in its report to Congress, entitled *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*. Their findings yielded a strong link between staffing and quality. They found that preferred minimum levels exist, above which quality was improved across the board. The total preferred minimum level was 3.45 hours of care, with a staffing mix of aides, RPNs or equivalents, and RNs. They also found that residents in understaffed homes are at greater risk of preventable health conditions, including pneumonia, urinary tract infections, sepsis, congestive heart failure and dehydration.

—The coroner's jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.



—A recent study published in the American Journal of Public Health, on July 1, 2005, by researchers from the University of Toronto and the University of Maryland found that for each hour of care, injury rates for nurses and nurses' aides fall by nearly 16%. For every unit increase in staffing, worker injury rates decrease by two injuries per 100 full-time workers. The study authors concluded that the more hours of care provided per patient, the fewer the workplace caregiver injuries, which leads to better care.

The bill should be amended to require cabinet to reinstate a minimum staffing standard by regulation. The regulation should require a minimum standard of 3.5 hours of hands-on nursing and personal care per day. There should be clear standards, special care units, and improved training requirements and opportunities to provide appropriate care for residents with behavioural problems or cognitive impairment, and especially those with a history of aggression.

The Ministry of Health and Long-Term Care must immediately update to the comparative work done by PricewaterhouseCoopers in 2001. The review must include, at a minimum, the current levels of acuity and the current actual levels of care. The review must also include an assessment of the evidence-based appropriate minimum staffing standard—to be weighted by assessed need—that is required. This information must be made public.

In addition to the requirement for cabinet to set a minimum staffing standard, there should be a process to require a regular three-year review by the standing committee covering the same information to ensure that care needs and standards are being met. This information must be made public.

There must be a clear requirement for a provincial funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding for the required staffing standard and strong accountability as to how money is spent.

There needs to be a clear standard to prevent the off-loading of patients from acute care facilities to long-term-care homes that are inadequately staffed to provide appropriate care.

With this research and these recommendations, one might think you have heard this before. I hope you have. I bring this information to you to ensure that you hear it as many times as necessary for you to believe that it is the best course of action in defending our parents and grandparents in their days that require the best level of care in their most vulnerable years. This is about dignity and respect. Front-line staff are the best source of information, not only because it's their job but because they care for residents. They speak up for many who don't have their own voice and strengthen those who do. Many other issues are connected to this, but without minimum standards connected to front-line direct resident care, nothing else can build the foundations needed to keep our

long-term-care beds safe and respectful of those who need them.

I turn it over to Janice.

**Ms. Courtney:** My name is Janice Courtney. I am a CAW chairperson at a long-term-care facility in Woodstock, down the 401 there near Toyota. As an employee for over 20 years at this facility, things are not good. As a daughter of parents and numerous relatives who need assisted living, I am outraged. Conditions have to improve, and quickly. How? Well, listen up.

Start to make informed choices. Become involved to make a positive change. I did not say that these parents and close relatives are all elderly. The residents of these facilities may be 38 with Lou Gehrig's disease or 49 years young afflicted with MS and only able to pull the call bell with his or her teeth. All residents require constant, reliable quality care.

If anyone thinks they'll be immune from having to have an affiliation with a long-term-care facility, think again. In the blink of an eye, a spouse, son or daughter is forced to make urgent alternative living arrangements for a loved one after a hospital stay expires. The loved one can no longer live independently, so the caregiver scrambles to try to secure a facility within the community.

**0920**

Super-soaker products are the ideal remedy to fix staffing shortages. Toileting is an option. Bathing maybe twice a week is a luxury. Going for a walk becomes a hazard because no one is available to accompany you for a breath of fresh air. Meal service is an assembly line because asking for personal assistance is an inconvenience.

When a resident hears "Wait just a minute" after a call bell has been answered, it turns into a half-hour wait because someone else has been deemed an urgent priority. Who decided this?

Regulations are implemented for a reason and a necessity. Usually regulations are to protect society from harm.

I urge you to make a generous, guaranteed standard of care, allotted for each and every resident. Society cannot ignore long-term-care residents. A 3.5-hour-per-day standard would be what politicians need to include in Bill 140, and it should be clearly enforced and guaranteed.

Bill 140 can be made even better.

**The Chair:** You've used the entire 15 minutes, so unfortunately there will be no opportunity for questions. Thank you.

#### CANADIAN AUTO WORKERS, LOCAL 27 RETIREE CHAPTER

**The Chair:** The next presentation is by the Canadian Auto Workers, Local 27.

Welcome. Please state your name for Hansard. You have a total of 15 minutes.

**Mr. Hector McLellan:** I'm from the retiree chapter. I would suggest that we speak a bit louder, because I've

got a whole story to tell you about my hearing aid which disappeared. It became doggie kibble, so I can't hear too well. I'd appreciate it if we could raise our voices a few decibels so that I can hear.

Roland Parris from the retiree chapter is here with me. He's my interpreter.

**Mr. Roland Parris:** I think we should emphasize the fact that we are with Local 27, but we are a retiree chapter, which is a separate body within the local. So we are here representing people who will be using those nursing homes. I'll tell you, we have 100 people coming to our monthly meetings. They'll be very, very eager to see what sort of response we get from you guys—because, remember, we vote.

**Mr. McLellan:** The submission I am presenting today is to generate some feedback from the committee—because it won't be too long until all of you are going to be retirees. All of you may be finishing up in a long-term-care home. I hope not, but it does happen.

Thanks to the committee for the opportunity to make this presentation on behalf of senior citizens affiliated with the Canadian Auto Workers, Local 27 retiree chapter, and also on behalf of senior citizens affiliated with the Ontario Federation of Union Retirees.

I am vice-chair of our retiree chapter in London and I am second vice-chair of the Ontario Federation of Union Retirees, and between the two organizations, we speak on behalf of thousands upon thousands of unionized retirees and their families.

I would like to ensure that this committee is focused on the true stakeholders, our senior citizens, who will be affected by the final outcome of this legislation once it has had third reading and final royal assent. As a social society, our responsibility is to ensure that the welfare and dignity of our senior citizens is uppermost in the passing of this bill.

As a senior, I dread the thought of having to go into care and being separated from the members of my community. My research shows that most of our older citizens share the same view.

Our seniors' community has a great sense of pride in looking after their own needs and not depending on others to care for them. When care is needed, our first priority should be care in our own home and in our community.

On the reading of this bill, my first thoughts were, "It's a well-written piece of legislation—long legislation." I suppose that's part of the job of government. They have to look into what's going on within these homes. But on reflection, I find that some of the provisions missing or not stated in this bill could have a profound negative impact on the care of our senior citizens who are in long-term-care homes.

Before this bill is passed, there has to be more consultation on private long-term-care facilities versus public and non-profit long-term-care facilities. Private facilities must make a profit, and the profit has become the priority over the care and protection of residents.

University Ph.D. candidate Michael Hillmer's recent report noted that non-profit care performed better than for-profit care. His study found that non-profit performed better than for-profit, especially in the measure of patient care. Findings in the for-profits included higher rates of pressure ulcers—bed sores—and the use of psychoactive medication to subdue patients. Can you imagine your loved ones being subdued because the nursing staff doesn't have the time to look after them because of the pressures of understaffing? These conclusions were echoed in the June 2005 study conducted by the University of Toronto on caregiver injuries and staffing levels. Lead researcher Dr. Charles Muntuner states, "Reduction in staffing ratios and number of staff hours lead to a lower level of care."

The current practice of tendering non-profit beds to for-profit beds has to end. Senior citizens' needs in long-term health care facilities should not be subject to the whims of the marketplace. Status of Women Canada found that home care recipients and their families are paying out of pocket for many services, including drugs, equipment and housekeeping. The same services provided in a hospital would be free. The money-making potential in home care is huge and the private sector has taken sharp note.

My information has said that globally, health care is a \$5-trillion business. Business is looking at this very carefully. Business wants to get as much of this five—I don't even know what a trillion is, and I'm sure most of us don't know what a trillion looks like. But the business community and corporations, especially in private home care, are really looking at this business.

Standard of care: We must address this issue and establish a minimum of 3.5 hours per patient per day as a minimum standard. At present, the government uses an assessment tool to figure out how much care a resident needs. It has been suggested that this method is flawed. The government is piloting a new assessment tool in 70 long-term-care homes based on case mix. This approach makes it very difficult to assess the average needs of residents and in turn makes it difficult to determine staffing and funding to ensure adequate care. In 1996, there was a minimum level of 2.5 hours' care per day per resident. It was removed by the Conservative government, and to this day no standard has been set, as per my research.

The provinces of Alberta, New Brunswick, Nova Scotia and Saskatchewan are all looking to set a minimum standard of between 3.1 to 3.6 hours of daily resident care. A minimum of 3.5 hours per patient can be measured, and staffing and funding would be better able to be assessed. Until this has been established, there needs to be more consultation before the bill is proclaimed.

**0930**

Staffing and qualifications: This is another area that needs further consultation, as it has been recognized that underqualified and understaffed long-term nursing homes have led to staff and residents being assaulted. In the last



five years, violence in nursing homes has shown a sharp increase. In the year 2004, violent residents attacked other residents 864 times and attacked staff 264 times—a 10-fold increase in five years. This statistic came from CBC news, April 10, 2005. There have been 11 homicides in Ontario and 3,000 reported attacks. This came from the Ontario Nurses' Association's submission to a coroner's inquest into the deaths of three residents at Casa Verde Health Centre. I have not been able to find out if any of the coroner's recommendations have been implemented. Maybe the committee can share that information with me, if they have it.

In conclusion, the new act will impact millions of Ontarians who are at their most vulnerable time ever in their life—and we all get there; we all become part of that. It's up to our legislators and citizens of Ontario that, before Bill 140 is proclaimed, it be written to ensure that senior citizens of Ontario are cared for with dignity and respect. Thank you very much.

**The Chair:** There are about four minutes left. If there are questions, I will start with the official opposition.

**Mr. Ernie Hardeman (Oxford):** Thank you very much for the presentation. I noticed that there were a number of concerns expressed with the bill that you would like improved.

I'd just like to ask: If there was one thing you could recommend that should be changed in the bill, as it seems evident that the government is not going to hold further public hearings and public consultation on it, that would make it better for the people whom you're here today to represent, what would it be?

**Mr. McLellan:** I would say staffing levels.

**Mr. Hardeman:** If I could go a little further with that: I noticed you mentioned in your presentation that the case mix requirements—the pilot projects—are not meeting the needs of the people. How would you say that the 3.5 hours per resident would serve all the residents in all the homes differently, recognizing that we have different levels of needs in different homes? We have some that have a lot of patients who need a lot of care and some that have patients who don't need as much care. Without some kind of case mix identification, how would you deal with that?

**Mr. McLellan:** It would be a matter of budgeting. Once you know how much time your staff has within a 24-hour/seven-day-a-week facility, then once you have a standard set, a particular standard of 3.5 hours or even more—the standard of 3.5 hours is minimum. The RNs, I believe, have maybe less than an hour to look after patients. That's an RN. There are, especially in private facilities, other people who are looking after patients and who are sometimes not adequately trained. But trained 3.5-hour nursing staff can be budgeted. You can put a number on that and submit that.

**The Chair:** We need to move on to the third party.

**Ms. Shelley Martel (Nickel Belt):** Thank you, Hector and Roland. I'm sorry to hear about your hearing aid, Hector. I hope you get that sorted out soon.

**Mr. McLellan:** This is my new hearing aid. I put my hand over my ear to hear you.

**Ms. Martel:** Just with respect to the responses to the Casa Verde inquest: You can get a copy of the government's response to the recommendations from the Office of the Chief Coroner. They were released this summer. I got one for free, so hopefully you will too. If not, you can let me know.

I want to focus on the staffing standards, though. It's clear that if you have a minimum standard—and you should; I have been pushing for a minimum of 3.5 hours—it also requires an increased investment by the government to fund the staff necessary to put that in place. The government made two promises: first, that they would reinstate a minimum standard; secondly, that they would fund each resident and increase funding for direct care by \$6,000. So if you actually provide that \$6,000, you can hire the staff. Unfortunately, the government has only provided about \$2,000 of that \$6,000, so they have a long way to go.

You've talked about some of the studies, but in a more direct observation, what is it about minimum standards? Why is it necessary to have minimum standards if you're trying to provide the care that is needed for the residents in our homes?

**Mr. McLellan:** I can answer that, but I'll give Roland a chance.

**Mr. Parris:** No, go ahead.

**Mr. McLellan:** Okay. Just as I said to my friend—I can't even see your names now.

*Interjection.*

**Mr. McLellan:** No, you're not Elizabeth.

**Mr. Hardeman:** Ernie Hardeman.

**Mr. McLellan:** It's all a matter of accountability and budgeting. Just as I said to Ernie, if you have a standard you can budget on, I think it's plain accounting. We have to get this bill right, and once we get it right and it satisfies the needs of the seniors, then we can talk about monies. If the people of Ontario know that their taxes are going to a worthwhile project, like minimum standards for health care within nursing homes and long-term care, I don't think you'll have much trouble selling that. I don't know if that answers your question.

**The Chair:** I need to move on to the government side.

**Ms. Monique M. Smith (Nipissing):** Just to remind Mr. Hardeman, there was all-party agreement as to how many days of hearings we had on this. It wasn't the government that decided.

I want to respond to a couple of the concerns you raised. You talked about the continuity of care or the spectrum of care and that people want to age at home. Certainly I heard a great deal about that, and our government has tried to address that with some investments in home care to ensure that people can stay in their homes as long as possible.

You raised a concern about psychoactive medication and the use of medication and restraints. We've put some limitations in the legislation around minimum use of restraints, so we're only using them in rare circum-

stances. And around medication, it can only be prescribed by doctors, and those orders are reviewed on a regular basis. So we have put controls around that.

You asked about the Casa Verde inquest. One of the recommendations in the inquest was that we do broader assessments of our residents prior to them coming to a home. You'll see in the legislation where we've got quite a system of assessment presented. It includes a behavioural assessment not just of the recent past of the potential resident but of one year prior, so we get a better sense of what their behaviours have been so that the home can best address the resident's needs when they arrive.

On minimum standards, you talked about the RN time. We've had a lot of input from different people about who should be included in that 3.5 number. Who would you include in the number? What caregivers would you include in the calculation of 3.5?

**Mr. McLellan:** To start with, a trained professional, and that would be the RN. That's who I would have there. There are other facilities that have to have—

**The Chair:** I'm sorry, but we're over. Thank you.

### COUNTRY TERRACE

**The Chair:** The next presentation is from Country Terrace. While they're coming forward, I would note that there are beverages—water, coffee and juice. If you wish to partake of them, just quietly come forward and grab what you would like.

Welcome. If you would state your names for Hansard, please.

**Ms. Mary Raithby:** Good morning to each of you. My name is Mary Raithby and I am the executive director of Country Terrace long-term-care home. With me is Kevin Concannon, chairperson of our family council. We are here representing Country Terrace, which is the best long-term-care home in Middlesex Centre. Country Terrace is home to 120 residents and employs approximately 110 staff, many of whom have worked here for over 20 years. We are a charitable, non-profit home in a rural community.

0940

My background is in nursing, as I am a registered nurse. I have worked in long-term care for over 20 years, starting as a charge nurse, becoming director of nursing, and then executive director for the last 14 years. As well, I am actively engaged with the South West LHIN and the identified priorities in the integrated health service plan.

Kevin and I are here to speak for our frailest and most vulnerable citizens: our seniors. We are asking you to remove the uncertainty that Bill 140 creates for our residents, their family members and our staff.

We support the bill's strengthened provisions for resident safety, abuse prevention and whistle-blower protection. We are disappointed, however, that while the legislation took three years to write, it will introduce limited-term operating licences linked solely to a building's structure. There is no plan to reassure Country

Terrace, our residents, families, staff and volunteers that we will be here or able to meet increasing demands, or that our home can meet resident expectations for privacy and dignity.

Without a plan, Country Terrace, like other families, staff and 27,500 residents in C homes, will be left wondering on what day in the next seven years the ministry will decide to reveal our future. The options for us in this bill include: close the home; close some of our beds; rebuild—which is impossible without a capital renewal program; invest millions in upgrades and still leave us with three- and four-bed wards; or renew our licence with no changes, again perpetuating three- and four-bed ward accommodation. All of this without an appeal process.

The worst option is hearing nothing in seven years. Ministry silence means our home will close, and subsection 101(5) allows them to not explain their decision to anyone. This is hardly reassuring for our residents, families and staff over the future of their home, their care or their job.

In addition to this uncertainty, there is subsection 103(9). It states that "a non-profit entity may not transfer a licence or beds to a for-profit entity except in the limited circumstances provided for in the regulations." This places non-profit homes like ours at an unnecessary disadvantage with regard to sales and will affect the value of our homes.

**Mr. Kevin Concannon:** Bill 140 states that "a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort." The preamble of this bill states that "The people of Ontario and their government... Affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term-care homes." Amendments are needed to ensure that this is met.

My family and I chose Country Terrace because of its history of excellence in care. Its structural classification is C, which means that we are paying the same amount each month as others in A homes and are receiving much less in accommodation. Where does this bill address this issue?

Country Terrace has three- and four-bed ward rooms. It does not have smaller resident home areas. It does not have on-unit dining areas. My mother eats in a dining room with over 60 other people every day, for every meal. The issue of privacy in shared rooms is apparent to us each day. You and I would not find this acceptable. Why should we subject our seniors to a lack of privacy?

Bill 140 does not even address these issues. These are the things that matter to us and our families. What assurance does this bill provide? If this bill is going to guide long-term-care decision-making for the next 30 years or more, we expected much more. Government must be empowered to fund a capital renewal and retrofit program and act on its support for Elizabeth Witmer's recent motion.



For a bill that took three years to write and, during that time, did not have wide stakeholder engagement, it is no wonder so many issues exist and are being questioned. For example, does it really make any sense to communicate the zero-tolerance-of-abuse policy to everyone attending or visiting the home? Does the person delivering flowers really need to know this policy? Would it make my mother's care better in any way, or will it compromise her care because the very staff needed to provide care for her will be communicating a policy and not available to our family members?

Bill 140 obviously does not meet the commitment stated in its preamble. Our seniors must not be forgotten. They are the very people who built our province for us and those who follow us. Your bill must support the future viability of long-term care now and in the future. We can do better for those who will depend on this type of care. We ask that your report include the necessary amendments to strengthen this piece of legislation in practical terms in order to meet our commitment to the people of this province now and in the years to come. Our seniors and their families are depending on your committee to make sure the government gets it right. This bill is not good enough.

**Ms. Raithby:** Country Terrace is a vital part of the social and economic fabric of Middlesex county. We deserve reassurance that there will be homes available for our most elderly, frail and vulnerable citizens and that, structurally, these homes meet resident expectations for physical comfort and privacy.

The government now has the opportunity to take the critically important first step to foster the successful and sustained renewal of Ontario's remaining 300 older homes. You can amend Bill 140 to remove the existing uncertainty and articulate your commitment to develop a comprehensive and appropriate capital renewal and asset management program.

The Ontario Long Term Care Association has worked within the government's proposed fixed-term licensing framework and presented a solution that removes Bill 140's uncertainty, provides a clear plan for the future and addresses the key bed-planning and structural-renewal questions. This solution recognizes that licences should not be perpetual but should be linked to criteria that support care and service needs.

For the licence to be renewed, the operator must demonstrate that there is continued demand for the beds in the community; the home does not have ongoing, unresolved compliance issues; and the home is structurally fit to meet the needs of the residents. This is a workable solution, and we ask you to refer to the submitted proposal.

We are at a time when long-term care is desperate for the government's support. We are at a time when staff is leaving us because the workload, standards and regulations place them in no-win situations. When all staff wants to do is provide care and services to our vulnerable residents, they are scrutinized, burdened and broken. Many managers can no longer take the pressure placed on them by the system and are leaving our industry.

It has been said that bad things happen when good people look away. We, the residents, families and staff in all C homes will not look away. We will look into your eyes and ask you to make a difference in the life of each of us. We will not look away today, this month or this year. You have been entrusted with an enormous responsibility and we need you to act. You have been given a chance to make a difference and we expect you to take it. We will not look away.

Thank you for your time.

**The Chair:** There are about four minutes left. I will start with the third party.

**Ms. Martel:** Thank you for your presentation here today. I want to focus on your page 2, at the middle of the page where it talks about the preamble of the bill and outlines the principles and then says at the end that amendments are needed to ensure that the principles in the preamble are met. Can you just reinforce or go over for the committee some of the amendments that you have in mind that are required to make sure that those principles can be met?

0950

**Mr. Concannon:** Yes, thank you. My mother has been in a nursing home for a year and a half, and I'm learning things every day. Specifically, I don't see—while I didn't expect the actual funding in this bill, I expected that the government would make some reference to a retro-build commitment. I don't see that here. Some of the amendments—in talking to Mary and other people at Country Terrace, I think the government is putting in far too much increase in administration and taking away from the actual care. It just doesn't make sense to me to explain a policy to a delivery person who probably doesn't care, to be quite honest, when they're just coming in and leaving something at the front desk and leaving.

The issue of care, 3.5: I have a problem with insisting on 3.5 for everybody because obviously some people will need more than that, and I don't think my mother needs that at this point. I think some of the amendments that I'm concerned about are increasing care and eliminating the administration, the paperwork that staff have to do. If it's necessary, that's fine. If it's not, let's not—as I mentioned in my comments, let's be practical. Let's run it with the emphasis on care. Yes, we have to have administration and paperwork, but let's keep that to a minimum.

**The Chair:** Questions from the government side?

**Ms. Smith:** Thank you for your presentation. I want to congratulate you on running such a great home. I know that you've had no "unmets" in the last few years, so you're doing a great job. And, Mr. Concannon, thank you for serving on the family council.

I did want to address one concern that you raised, and that was that there was a lack of consultation on this legislation. I personally caught my breath when you said that. I actually did a review of long-term care in 2004 and issued a report in the spring of 2004 called the Commitment to Care. During that time, I visited over 35 homes

across the province. We issued a white paper in the fall of 2004 and received 754 submissions in response to that white paper, which were fed into the process of drafting this legislation. We met with 35 stakeholder groups and subsequently received 57 briefs from stakeholders on the drafting of the legislation. We held public meetings in seven locations throughout the province, including in southwestern Ontario. And in this committee process we will have heard from about 120 more groups as we travel the province. So I think we have done our homework and certainly have a great deal of public consultation, as well as consultation with those front-line workers who are involved.

I did want to ask a question about the management of your home—

**The Chair:** A very brief question, a four-second question.

**Ms. Smith:** Very quickly. Do you presently have an approval or a licence, and if you have an approval, doesn't transferring over to the licence scheme give you at least more flexibility than you presently have?

**Ms. Raithby:** We are licensed.

**Ms. Smith:** You are licensed. Okay, thanks.

**The Chair:** Thank you. Mr. Hardeman.

**Mr. Hardeman:** Thank you very much for the presentation. I do want to say, in response to the government side's lack of consultation, the part that I want to ask a question about is "had no discussion in the process," which was the limiting of the licences. I don't believe that was part of the parliamentary discussion paper or subsequent consultation. In your presentation, you mentioned the fact that the licences have to be renewed in a maximum of 10 years down the road. In your report you also say that they should be renewed based on "the home is structurally fit to meet the needs of the residents." My understanding is that the reason for the limit on the licence is because the government doesn't believe that the standard that you presently have will be sufficient to renew the licence; they'll look for progress in the system. How would you envision that your non-profit home would deal with that process without some type of government program to help the capital funding?

**Ms. Raithby:** We can't. It would cost us \$15 million. We are run by a volunteer board; we have a \$6-million mortgage. We would not be able to do this without a capital renewal program. And in addition, the other residents in the province got that, the ones who are in the A homes. So we're asking for our residents the same as was given by the province to the other residents.

**The Chair:** I'm sorry; we're out of time. Thank you very much for presenting to the committee.

#### SARNIA HEALTH COALITION

**The Chair:** I'll call now for the Sarnia Health Coalition.

Please state your name for Hansard.

**Ms. Helen Havlik:** Good morning. My name is Helen Havlik. I'm with the Sarnia Health Coalition. This is

Arlene Patterson, who is the chair of that group. Thank you for having us here this morning. We have provided you with 20 copies of our presentation. It's fairly lengthy. I don't intend to read it all. I know you've heard quite a bit of it already, so I'm just going to emphasize certain parts of the presentation.

I'm going to page 7 of our presentation, the paragraph that starts with "Inaction on the Provincial Auditor's recommendations."

The Provincial Auditor, in 1995 and 2002, noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PricewaterhouseCoopers report and inadequate tracking of contagious disease outbreaks.

In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. In the minutes of the standing committee on public accounts, it is reported that the government has been collecting actual staffing data for several years. However, we have not been able to obtain these data. If the auditor's complaint that there is no assessment to determine the adequacy of funding to meet assessed need has been addressed, that report is not available publicly. No staffing standards have been created. The ministry has never updated or addressed the findings of the 2001 PricewaterhouseCoopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies, while having significantly older residents with complex care needs, including depression, cognitive impairment and behavioural problems.

How does our proposed minimum standard work? The government uses an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool in 70 long-term-care homes. The tool allows facilities and the government to determine the case mix. The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity. Those with heavier care needs are deemed to have higher acuity. The funding the home receives for nursing and personal support care such as feeding, bathing, nursing, etc., is based on the level of acuity in the home.

However, there is no expected amount of care that is attached to the average level of acuity. An array of reports and media exposés and testimony of families and care staff have shown that there are serious inadequacies in care provision. There are not enough staff to provide the needed care. Staff are unable to get their care work done to expected standards within the time they have on their shifts. Bathing, repositioning, referrals to medical care, even feeding, are left undone.

A care standard would set an expected level of care, weighted by the assessed acuity of the resident. This



would provide one of the most important tools in the assessment of appropriate funding and provide greatly improved opportunities for accountability.

Now I'm going to go to page 9: support for public and non-profit care. This is another issue that we have a lot of problems with. For-profit nursing homes are required by investors to maximize the profit and growth potentials of their companies. The investors in Diversicare, Extendicare, Chartwell or the others seek to maximize the rate of return on their investment and to pursue a growth strategy that maximizes return down the road. That means profit has to be found from the mix of government—public—funding and private fees that residents pay.

**1000**

In Ontario's nursing homes there are several funding envelopes, including nursing and personal care, programs and support services and accommodation. Only in the accommodation envelope do facilities keep funding if they do not spend it all. In the nursing and personal care and programs and services envelopes, the homes must return funding received from the government if it exceeds what they spend. In the for-profit facilities, this means that the accommodation envelope is the one from which they can take profits. This is also the envelope into which go premiums charged for private and semi-private beds.

Over the years, the operators have done a number of things to shift costs from the accommodation envelope into the nursing and personal support envelope, including moving incontinence supplies, moving costs for building cameras and surveillance equipment, and shifting the work of accommodation staff to personal support staff. The fewer the costs in the accommodation envelope, the more room for profit-taking. In recent years, it has been reported that the government is directing the operators to move incontinence supplies and surveillance and security costs back into the accommodation envelope so that nursing and personal care funds are not siphoned off into these other items. We are now hearing reports that this has not yet been done.

The operators have also conducted public campaigns and lobbying to increase the amount of funding in the accommodation envelope. The fee increases for residents adopted by the Harris-Eves Conservative government go into the accommodation envelope.

The for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing home industry are in direct conflict with the public interest in accessible and affordable care. I'm not talking here about those nursing homes that are run by a sole operator; I'm talking about the large for-profit groups.

Beds for care or revenue streams for investors? Ontario's non-profit and public facilities have always had approved beds, which means that the number of beds

they operate is approved by the provincial government. The for-profits have licensed beds, which have a value on the open market. Thus, for-profits can buy and sell bed licences as revenue streams for their companies. Nursing home beds are places of care for vulnerable seniors. Most Ontarians would be appalled to realize that the for-profits see them as commodities to be bought and sold for investor revenue streams.

The mission of a non-profit or public long-term-care home is to provide care. This is incorporated into the agency's bylaw and letters patent as the reason the home exists. The mission of a for-profit nursing home is to maximize profit and growth for its shareholders. So a non-profit is founded on the principle of putting the most it can into the home. The for-profit requirement to deliver maximum rate of return and growth means that it must take the most it can out of the home.

To a for-profit, long-term-care homes are an investment. They move from jurisdiction to jurisdiction, depending on the market conditions. For example, after Extendicare was sued in Florida for deaths in their homes due to dehydration and bed sores, which the court ruled as neglect, they sold off their facilities in the state and moved shop. Ironically, while Extendicare was given the largest penalty in a civil suit in history in Florida for the deaths of residents in its nursing homes, Ontario was awarding the company the single largest share of our new beds. While we think of nursing homes as a place to live for our aging parents, spouses or friends, Extendicare Canada sees these homes as one part of its portfolio, providing a revenue stream to investors as follows: "Today, the company is focused on growing its business in both the assisted-living and nursing home sectors of senior care. The company expects to continue making selective acquisitions to increase the size and scale of its portfolio." You can see that on this website, where it has been since December 19, 2006: [www.extendicare.com/aboutus/history.html](http://www.extendicare.com/aboutus/history.html).

Research from well over a decade of experience in the United States shows that care in non-profit and public long-term-care homes is superior to that of for-profit homes. When releasing his recent study showing better performance in non-profit versus for-profit nursing homes, University of Toronto Ph.D. candidate Michael Hillmer noted that the differences "could be as simple as them being required to put any profits back into the homes." His study found that non-profits performed better, especially in measures of patient care, than for-profits. Findings in the for-profits included higher rates of pressure ulcers—that's bed sores—and use of psychoactive medications to subdue patients, and more use of restraints.

His conclusions were echoed in the June 2005 release of the University of Toronto/University of Maryland study on caregiver injuries and staffing levels in nursing homes. Lead researcher Dr. Charles Muntaner stated, "Reductions in staffing ratios and numbers of staff hours lead to lower quality of care. At the end of the day, it's a policy option, but the consequences are clear. If you try

to squeeze the budget to maximize profits, it creates the dangerous situation we see in the United States.”

In his investigative report on Ontario's long-term-care homes, Ottawa Citizen reporter Paul McKay reports on the claims of the for-profit lobby group the Ontario Long Term Care Association as follows: “Karen Sullivan contends her members make no profit on the provincial subsidies. Instead, she says, they earn their profits by charging higher fees to wealthier residents who can afford private rooms, and by buying food and other supplies in bulk and setting lower wage scales for staff.” Despite the spin, even the for-profit association admits that cutting on food and staff costs and charging higher fees is the practice for maximizing profit-taking from the homes.

Conversely, municipalities are pouring funding into the operational budgets of the facilities to improve care. Non-profits fundraise to provide activities and amenities. They act to levy additional resources to put into the homes.

I won't read the next section; I'll just go down to subsection 103(9).

**The Chair:** About one minute left.

**Ms. Havlik:** Subsection 103(9) of the proposed legislation allows non-profits to transfer to for-profits as per regulations—unspecified. There is no requirement that homes be rolled back into non-profit or public control. We have expressly opposed non-profit to for-profit transfers. Later in the “Transition” section it is specified that non-profits with licences will continue to have licences; those with approved beds will continue as such. Currently there is a mix of approved and licensed non-profits. In the fall of 2006, the government put out to tender new beds in southeastern Ontario, following the tender process established by the Harris-Eves Conservative government, which is weighted towards the large for-profit chains, with their superior access to capital. These policies, combined, mean that the current majority of for-profit beds will continue, with provisions that new beds can be tendered to the for-profit sector, and more of the non-profit could be transferred—

**The Chair:** I'm sorry.

**Ms. Havlik:** Okay. That's it.

**The Chair:** Thank you. I assure you that the entire document will be read by the committee. There is no time for questions. Thank you.

#### SAINT LUKE'S PLACE

**The Chair:** The next presentation is by Saint Luke's Place.

If you would state your name for Hansard, please, and you have 15 minutes.

**Ms. Rita Soluk:** My name is Rita Soluk. I'm the administrator for Saint Luke's Place. Thank you for the opportunity to present this morning to the standing committee on social policy on Bill 140.

Located in Cambridge, Saint Luke's Place provides 114 nursing home beds, 40 retirement home beds and

129 independent-living apartments for seniors. We are a fully accredited, not-for-profit long-term-care home committed to promoting resident-centredness, advocacy and the residents' bill of rights. We value and support the principles of resident choice, dignity and respect, and are committed to the provision of quality of service in all of our initiatives.

As a not-for-profit charitable organization, we depend upon private donations, our foundation, and in-memoriam gifts to fund the acquisition of furnishings and equipment and to assist with the financing of our nursing home restructuring initiatives.

We support the fundamental principle of Bill 140; that is, to create a place where seniors “may live with dignity and in security, safety and comfort.” We support the need for clear standards and for accountability.

#### 1010

That said, we have major concerns with Bill 140. We believe that in its present form, Bill 140 will have serious consequences for Ontario's seniors and, equally important, our health care system as a whole. We are concerned that Bill 140 permits our government to abdicate its responsibilities for ensuring a resident-centred, responsive long-term-care system now and into the future.

Standards and compliance requirements without the necessary financial support from our government are a recipe for disaster. Rather than providing a plan to address current and future needs of Ontario's seniors, Bill 140 promises to erode care and services to our seniors, fails to recognize the already demanding workload of staff and fosters the institutionalization of seniors.

Fixed licensing terms threaten to exacerbate the current problem of insufficient long-term-care beds and create a situation where seniors' access to nursing home accommodation is seriously limited. Bill 140 provides the government with the ability to unilaterally close and relocate long-term-care beds without any requirement to explain or be accountable for this decision.

As evidenced by our structural upgrades in recent years, Saint Luke's Place recognizes and is committed to undertaking the structural changes that will enable us to meet the changing needs of our seniors. However, the government's ability to arbitrarily close those beds may cause us to hesitate to undertake future capital upgrades.

As is the case for all long-term-care homes, lenders will be hesitant to invest in our restructuring initiatives when there is no guarantee of re-licensing. Loans will come with higher premiums and shorter repayment terms, and donors may be hesitant to donate towards restructuring initiatives when re-licensing is not assured.

An equally important aspect of the fixed licensing term is the impact any reduction of long-term-care beds will have on access to hospital beds. Long-term-care homes are an integral component of the health care continuum and they play an important role in the hospitals' bed management system. Any reduction to long-term-care beds will result in an increased number of seniors awaiting placement in hospital beds. As a result, the potential exists for longer waiting lists and wait times for



medical and surgical intervention, further stress on our already overcrowded emergency departments and so forth. Fixed licensing terms affect the health care continuum as a whole, not long-term-care homes alone.

We believe fixed-term licensing is unnecessary if the government's goal is to control long-term-care bed numbers or to ensure compliance with standards. Section 102 provides the government with the ability to reduce bed numbers based on utilization rates in the community. Section 154 provides the government with the ability to revoke a home's licence and/or appoint an interim manager where a home is noncompliant with standards.

We strongly encourage this government to reconsider the need for fixed licensing term provisions in Bill 140. Additionally, we encourage the government to recommit to a capital renewal program. Without a recommitment to capital renewal, renewal of the long-term-care sector is not affordable, the current double standard for seniors' accommodation is perpetuated, and the fundamental right of seniors to live in comfort with the privacy and dignity they deserve is undermined.

Rather than heeding parliamentary assistant Monique Smith's recommendation that "strategic efforts need to be developed to promote the long-term-care sector as a desirable career option as staff shortages and pay inequities are constant challenges," Bill 140 in fact creates additional barriers to recruitment and retention of staff in long-term care. The fixed licensing term eliminates job security for staff, thereby discouraging employment in long-term care, and the increased documentation and reporting requirements result in an increased workload for already overworked staff. Job insecurity and excessive workload are cited consistently in the research as having a negative impact on recruitment and retention of staff. From the resident care perspective, increased documentation and reporting demands will erode the time available for staff to provide resident care, increased recruitment and retention costs will reduce the funds available for direct care provision, and staff turnover will undermine the ability of long-term-care homes to build skilled and knowledgeable health care teams capable of meeting the complex care needs of our seniors.

While we support the need for standards and accountability, we support OANHSS's recommendation for this government to analyze the financial burden of the new administrative demands and, at a minimum, increase operating funding to offset the related costs.

Bill 140 introduces an additional and significant source of personal liability for board officers. Board officers will be held personally liable for any breach in the act by anyone in the nursing home. For a first-time offence, officers will be subject to a fine of \$25,000 and/or imprisonment for up to one year. Not-for-profit nursing home board officers are volunteers. They donate their time, knowledge and expertise, with the end goal being that of enhancing the quality of life for seniors.

The additional obligations and penalty provisions are a major concern for our board members. We have been advised that our board's directors' and liability insurance

will not cover anything to do with this law. The introduction of personal liability will make recruitment and retention of board members extremely difficult.

We recommend that board officer liability provisions in Bill 140 be amended to mirror the provisions set out for board officer liability in the Public Hospitals Act.

Finally, the government is well aware of the fact that Ontario's long-term-care sector's funding is less than the Canadian standard of three to 3.5 hours per resident per day. Long-term-care underfunding, along with the additional demands created by Bill 140, will compromise the ability of long-term-care homes to meet the standards set out in this legislation. Equally important, the ability of long-term-care homes to sustain the current levels of care and support to seniors will be compromised.

Bill 140 demands that long-term-care homes do the impossible; there is no requirement for the government to be accountable for funding the changes. While current legislation states that the government "shall" fund long-term care, Bill 140 states that the government "may" fund long-term care. While we appreciate the health care funding challenges of our government, our government must commit to financing the current care and service needs of long-term care and the additional funding requirements that result from the demands created by Bill 140.

In conclusion, we request that you give consideration to the concerns that we've expressed regarding Bill 140. While changes are required in long-term care, we are concerned that the proposed legislation includes provisions that will seriously undermine the rights of seniors for accommodation and for quality, responsive resident care.

We believe that Bill 140 in its present form will create undue hardship for long-term-care homes and compromise the care and support provided to our seniors. While we support the need for standards and accountability, the proposed legislation will serve to redirect our already scarce resources away from direct care provision toward meeting the administrative requirements set out in the act. Additional funding is required to support the current and evolving health care needs of our seniors, ensure compliance with proposed standards and facilitate the needed structural renewal of long-term-care homes.

**The Chair:** Thank you. We have about one minute each for questions, starting with the government side.

**Ms. Smith:** Thank you for your presentation. I wanted to ask you a couple of questions about the funding that you raised. You talked about Ontario's long-term-care sector's funding being less than Canadian standards. We've actually invested over \$740 million in the last three years, and I understand at Saint Luke's you've been able to hire about 10 full-time equivalents with the funding that you've received over the last couple of years from our investments. Which staff members have you been able to include in your staff complement?

**Ms. Soluk:** All those additional staff members who have been hired have been hired for direct care provision, which is also the requirement set out in the funding,

which is not a problem. We're focusing on the direct care needs of our residents, and it's appropriate that's where the funds would go.

**Ms. Smith:** Absolutely, and I totally agree. We've seen an increase of about 4,800 staff across the province—front-line workers. Are there particular tasks that the 10 or 11 new staff at Saint Luke's have been assigned to?

**Ms. Soluk:** I would say that they would assume the same sorts of direct care responsibilities as any other individual, whether it's providing personal care, assisting with their activities of daily living. A number of the residents—and I know from your report you're well aware of the fact that we have an increased number of dementia or cognitively impaired residents across the sector. That dementia increases during the time they're there. You're well aware of the increased complexity; you cited examples when you talked about dialysis, catheter care, all sorts of things. You also recognized the increased dependency for transfer mobility, etc. All of those sorts of dollars that were provided have in fact gone towards doing that.

1020

**Ms. Smith:** That's great.

**The Chair:** We need to move on to the official opposition.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** Thank you very much, Rita. I know from personal experience that Saint Luke's is a much-beloved place. You've got a dedicated staff, and I appreciate your leadership. You emphasize the fact that a lot of this new documentation paperwork is going to take time away from the personal care, and we've heard that wherever we've gone.

You talked about the fixed licensing term. This is a move where the government didn't do any consultation, but it has the potential to create a lot of uncertainty for the sector in the reconstruction and renovation of their homes, and also for staff and what have you.

You mentioned that it's hard to recruit staff right now. Can you just explain why it is so difficult to recruit staff and why this will just further exacerbate the problem?

**Ms. Soluk:** Sure. I think Monique Smith talked a bit about it in her document Commitment to Care.

First off the bat, long-term care is not an attractive health care sector for people to work in. It's not seen as a flagship per se. If you look at something like cardiac transplants, that sort of thing, it's just not in that same ballpark.

Second, it's well acknowledged across the industry that the workload demands are significant. On any given day, if you take a health care aide, for example, they have an assignment of anywhere between nine, 11 and sometimes 12 residents for whom they're responsible for giving direct care. That means baths, feeding, dealing with behaviour problems for those who have cognitive impairment, and so forth. The registered staff support the front-line staff in that work and do those sorts of things. They also carry the bulk of the responsibility for the

documentation, medication distribution, treatment requirements. As I talked about a second ago, the treatment needs have certainly shifted. If you look at dialysis, the kinds of skin care that are required, it's not just about complex care needs; it's about the multiple systems that are involved. So the demands are significant. And it's probably the poorest-paid sector across health care.

**The Chair:** We need to move on.

**Mrs. Witmer:** Thanks, Rita.

**Ms. Martel:** Thank you for your presentation here today. I just want to focus in on the fact that Ontario's funding is not even reaching the Canadian standard of three hours per resident per day. The government has put out a number of about 2.8; I'm not sure what that's based on because I don't know that anything was released publicly to back that up. But even 2.8 is less than the 3.06 that was recommended in the Casa Verde inquest as what was absolutely necessary as hands-on care per resident per day. I suspect that if the government provided the remaining \$4,000 per resident that it promised, we would be able to get up to a higher standard and you would be able to hire more people to provide the personal care that you want to.

I'm also really concerned about the licensing. Given the consultations that apparently went on, we are in a situation where neither the for-profit sector nor the not-for-profit sector agree with the government's proposals on the licensing section. So I'm puzzled as to how we managed to get to that situation. What do you think needs to happen around licensing that would protect or aid your home and also allow you to do the redevelopment that you want to do?

**The Chair:** In four words or less.

**Ms. Soluk:** Okay. The bottom line is, I think it has to be eliminated. I pointed out that you can deal with bed numbers and failure to comply with standards under the other sections. Take away the licensing requirement and we'll be able to borrow money to move forward. People will have confidence in what we're looking to do. We'll have donors that support us, we'll still get our in-memoriam gifts, and we'll be able to move forward with a multi-pronged approach to funding those sorts of restructuring needs.

**The Chair:** Thank you.

#### VERSA-CARE CENTRE HAMILTON

**The Chair:** The next presentation is Versa-Care Hamilton.

Grab a seat and please state your name for Hansard.

**Mr. Sean Weylie:** Good morning. I'm Sean Weylie. I'm a concerned family member of three residents living in long-term care currently in the Hamilton area. I've worked for 11 years in the long-term-care sector in various management roles. I began my long-term-care career as a recreation manager and moved on to do some recreation consulting. I am also a past president of the Activity Professionals of Ontario, which has received a grant from the Liberal government to prepare a best-



practices manual for the recreation professionals in long-term care. I have been involved with the redevelopment of a D-class facility, and currently I am the executive director of Versa-Care Hamilton, which is a C-class long-term-care home.

Our home in Hamilton serves a unique population of younger seniors and people who normally would live on the streets or in psychiatric settings. With the downsizing of the psychiatric beds, we are now charged with the responsibility to care for these individuals. I am here today to ask the committee to make amendments to the proposed Bill 140 to ensure a superior quality of life for my relatives, for the residents of long-term-care homes and for a sustainable system, believe it or not, for me in the future.

The Commitment to Care report developed by Monique Smith was a good foundation for legislation to be developed on. However, during the development of this legislation, the true essence of the report was lost. Instead of creating a sustainable long-term-care system, the legislation has created uncertainty and an increased workload for professionals in the field.

The new act has many positive attributes that further support the residents' quality of life. Enshrining the residents' bill of rights and legislating zero tolerance for abuse are just two examples of the many positive resident safeguards in the legislation. The new Long-Term Care Homes Act, Bill 140, however, has serious flaws. The most glaring is the absence of the government's responsibility for funding long-term-care homes. Subsection 88(1) states, "The minister may provide funding for a long-term-care home." The government has a responsibility to all Ontarians to fund health care in the province. Section 88 clearly absolves the government of any financial responsibility for funding the long-term-care system.

Current funding levels continue to fall below those of similar demographic and geographic locations. This section of the legislation, as described in the OLTCA's Key Amendments to Bill 140 document, "allows for the withdrawal of the government's commitment to a publicly funded universal long-term-care program." According to an Ipsos Reid poll that was released on February 20, 2003, "Seven in 10 ... of Ontarians believe that funding for long-term care in the province should be a priority for the Ontario government," and "Nine in 10 ... Ontarians express agreement with the view that 'a government program should be put in place to allow existing long-term-care homes to be redeveloped to higher standards' that are in place for" the newly built homes in the province. This bill does not address either of these public opinions and does not make a clear and definite commitment to supporting the quality of life of our seniors.

Another Ipsos Reid poll, released on January 18, 2006, entitled *Canadians on Healthcare*, reported that "Canadians believe in equal access to health care: 90% of Canadians agree that access to health care should be exactly the same for everyone, regardless of their income." Without a commitment in the legislation to a

government-funded system, the seniors on reduced incomes face an uncertain future. Many of my residents are in a lower income bracket. They are concerned about whether they will be able to pay for the service if the government does not commit to funding levels that are appropriate to their care needs.

On a regular basis, our nursing staff are run off their feet. Many nurses have stated to me that they would love to be able to take the time to stop and get to know their residents better, but there just isn't time. My grandmother, who is in a long-term-care facility, has raised concerns about how rushed the staff are to deliver care. She is frequently encouraged to sit in a wheelchair to go down to the dining room instead of being encouraged to walk. My grandmother is capable of walking, but the staff on many occasions say they don't have time to walk everyone to the dining room.

#### 1030

This brings me to another section of the act that requires attention. Subsections 8(1) and (2) are of great concern. This would lead one to believe that restorative care is someone's job. Restorative care—and I have to stress this—is not a discrete and separate program but is a philosophy that every home should embrace. The funding model currently in use does not support the improvement of a resident's well-being. It penalizes homes that have taken on a restorative philosophy and a commitment to quality of life. The inadequate funding in the program and support services envelope does not allow the professionals the opportunity to adequately meet the legislative requirements. The government currently provides \$6.82 per resident per day to fund recreation, social programming, social work, dietitian, physiotherapy, occupational therapy, speech language pathology, etc. This translates into seven minutes of recreation or rehab care per resident per day. In seven minutes, the staff is expected to assist the residents to programs, provide the necessary services and then document the care provided to the resident.

The government is commended for their inclusion of recreation and social activities under section 9 of the legislation. This inclusion acknowledges that recreation and social activities are an essential service and therefore need to be funded accordingly. This section of the act speaks to the resident's quality of life. Recreation and social programming are activities that help normalize the life of a resident in a long-term-care home. In our own homes we do not have personal nurses, dietitians to develop our menus, cooks to prepare our meals and people to do our chores. We do have the ability to participate in leisure pursuits that interest us. Without ongoing government commitment to funding, residents' quality of life will be negatively impacted.

The care hours shortfall is not only applicable to the programs envelope but across all the funding envelopes. The residents in long-term care are requiring more care than before, as evidenced in the 3.15% increase in the provincial case mix measure over last year's results. Since 1992, there has been a 27.35% increase in the

provincial CMM. We can only expect that this trend will continue to increase with the growing number of Ontarians requiring long-term care over the next 15 years.

Furthermore, I have a concern about legislation that is so prescriptive that it restricts an operator's ability to be innovative and expand their services to residents. As an example, nursing staff diligently record the volumes of food and drink a resident consumes in a day. Is this really a dignified way to live out the rest of your years—having someone monitoring your consumption like a child? Why not use the weight loss and weight gain indicators to determine if a resident is at risk nutritionally? The legislation micromanages the long-term-care sector to the point where failure is almost certain. No operator will be able to meet every detailed section of the act 100% of the time. Registered staff are already moving out of the long-term-care sector, stating that the workload is overbearing and the focus on professional judgment and resident outcomes is being lost. Other examples of this prescriptive approach are clauses 4(1)(a) and (b) about mission statements—this restricts an organization's ability to develop a personalized mission that reflects the values of the home—and subsection 18(3), about communication of zero-tolerance policy—this section cannot reasonably be met 100% of the time. Under the proposed legislation every individual, including the plumber and the paper delivery person, would require this information even if they had no resident contact. Is this really reasonable to expect?

Prescriptive legislation makes these homes more like institutions, but the purpose of the legislation was presumably to encourage a more homelike environment.

The issue of licensing is also of real concern to my residents. Many of my residents have been asking me what they will do in seven years if we can no longer operate as a long-term-care home. Many of my residents are younger and do not have anywhere else to go. If the licensing scheme is not amended, the uncertainty my residents face is a reality. Some may argue that losing one home in an urban area like Hamilton or Toronto is not an issue because of the availability of long-term-care homes. But what about those who cannot afford to pay for a private room in a new long-term-care home? Most new homes have a two-to-three-year waiting list for their ward accommodations and they usually fill those internally before allowing the general public access to those beds. Versa-Care Hamilton has been extremely fortunate that our company had the vision three years ago to downsize our long-term-care home from 248 beds to 128 beds, and we created two-bed ward rooms. This is not the case with other homes in our area. Three- and four-bed ward accommodations are still a reality in our province and this is not a dignified way to live. The premise of this bill was to promote quality of life. The fundamental principle even states “that a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort.” The licensing scheme does not

provide any of the residents in B- or C-class homes with any security of knowing that they will have a place to live. I'm not very comfortable with the thought that not only could our residents be out on the street, but that my staff may not have jobs in seven to 10 years. I will find it very difficult to tell my employee, who has 30 years of service with our organization, that she no longer has a job. We employ over 190 staff and volunteers. This would have a significant impact on our community.

The government has the opportunity to make a commitment to the quality of life of our seniors and to allow them the opportunity to live in dignity. After careful review of the amendments put forth by the Ontario Long Term Care Association, as a family member and as an executive director, I urge the committee to support these amendments. We have the opportunity to create a bill that will be “the pride of Canada,” as announced by Minister Smitherman. We cannot be “care less” and have our seniors forgotten.

Thank you for your time. If you have any questions, I'll gladly answer them.

**The Chair:** Thank you. We have 40 seconds per question, I believe, for rotation.

**Mrs. Witmer:** Thank you very much, Sean. I guess what I find absolutely astounding as I continue to listen day after day, ever since the legislation has been introduced, is that this government has introduced the limited term “licensing” and created such uncertainty for staff and residents. I am appalled that there was no consultation and, furthermore, I am appalled that there has been no indication on the part of the government that they're prepared to make some accommodations and to introduce some recommendations. It just astounds me that they would put these people and the staff at that type of disadvantage, risk and uncertainty. I will tell you that I can't believe it.

**Mr. Weylie:** Neither can I.

**Mrs. Witmer:** I'm just overwhelmed. Thank you.

**The Chair:** Ms. Martel.

**Ms. Martel:** Thank you for your presentation. You focused on section 18, where you talked about having to communicate the zero tolerance policy. There's a similar provision under section 75 which goes even further, for those who are performing work at the home that's not defined, where you have to talk about residents' bill of rights:

“3. The duty under section 22 to make mandatory reports.

“4. Fire prevention,” etc.

What do you think this is going to do if you're in a position to have to talk to all these people about all of these things before they come to do work in the home—“work” which is undefined in the bill?

**Mr. Weylie:** In the bill, when it doesn't define what work is—and we're assuming that that's a contractor or somebody along those lines—that means that the average volunteer—being a former volunteer coordinator as well, it takes about an hour to orient a staff member or a volunteer to just the basics of a home. So if you have five



or six contractors come in in a day and you have to orient every single one of them, there's six hours of my day or a manager's day or a staff member's day used towards orienting those individuals.

**The Chair:** Ms. Smith.

**Ms. Smith:** Thank you for your presentation today. I feel compelled to respond to Ms. Witmer and Mr. Hardeman, who've been harping on this point today, and I don't know why, because their government wasn't exactly famous for consultation.

In our Future Directions document, our white paper that we put out before we started drafting legislation—I think you're familiar with it—we had the following questions: What factors should the ministry consider when designing a new licensing and bed approval system? What factors should the ministry consider when setting terms, time limits, on the licence or approval of a particular home—i.e., the physical structure? What criteria should the ministry use when deciding whether to renew a licence or approval? What criteria should the ministry use when deciding whether to revoke a licence or approval? Should the public have any opportunity to comment on the applications for a licence or approval, what methods should be used to allow the public to make such comments?

So, while I know this doesn't address your concerns, I did want to set their minds to rest, and I will provide you with a copy of the white paper this afternoon.

**The Chair:** Thank you.

**Mr. Weylie:** Actually, can I say one other thing to that issue?

**Ms. Smith:** Sure.

1040

**Mr. Weylie:** Even though the licensing scheme was put forth, the responses to the white paper were not addressed in this legislation. I did fill that out and I was a part of that whole process, and those comments and recommendations were not reflected in this legislation.

**Ms. Smith:** Well, there were 750.

**The Chair:** Thank you.

## PEOPLECARE

**The Chair:** The next presentation is by PeopleCare.

Thank you for joining us. Please state your names for Hansard.

*Interjections.*

**The Chair:** Please, save it for lunch. PeopleCare.

**Mr. Brent Gingerich:** Thank you for your time today. My name is Brent Gingerich. I'm owner-operator of PeopleCare. I'm here today with a valuable 22-year veteran staff member, Kathy Dingwell, who is PeopleCare's director of programming and support services.

PeopleCare is a family-owned and -operated group of three long-term-care homes: in Tavistock, with 100 residents; in Stratford, with 60 residents; and in Cambridge, with 90 residents. PeopleCare was founded by my grandfather 40 years ago, so I represent the third generation in this successful organization. We're extremely

proud of our reputation in the community for providing high-quality care in a home-like setting and treating our staff like they're part of the family. We're also proud of our innovations and achievements: PeopleCare was the first long-term-care home in Ontario to be accredited by the Canadian Council on Health Services Accreditation; we've been on the leading edge of medical practices and treatments for residents with Alzheimer's; and we've always have had an outstanding compliance record with the Ministry of Health and Long-Term Care.

We have three points for your consideration today: (1) creating a win-win Long-Term Care Homes Act; (2) enhancing the licensing provisions in Bill 140 with a plan; and (3) enhancing the programming provisions, which Kathy will talk about.

(1) Creating a win-win act: In my family's experience, in every generation there has been a major event in long-term care that has paved the way for the next. This is one such event.

The challenge in developing this act is to build on the positive progress and to enhance what's working and to attempt to address what's not working without destroying things that are working well. There are staff and operators out there who are doing fantastic work in this sector. Each and every article in Bill 140 has its own effect on this complex system, so one needs to be aware of those effects in order to make this act something really great and positive all around for the sector.

How do we do this? We need to have an in-depth dialogue with the experts in this sector. By doing that, we can create an act that is win-win. That in-depth dialogue has not happened.

This act could be win-win for the government, could be win-win for the clients and public, could be win-win for the staff and operators and could be win-win for owners and financiers. This is why the Ontario Long Term Care Association has proposed some 95 in-depth and detailed amendments. I'd encourage you to adopt these amendments as presented.

(2) Licensing: PeopleCare's three homes are classified as C by the Ministry of Health, which means the physical structures, the bricks and mortar, comply with 1972 nursing home standards but do not meet the newly introduced 1998 standards. My colleagues in the OLTCA and I have been advocating the government since the 1998 standards were introduced to develop a workable plan to get these 1972 C homes, which represent about 50% of the homes in the province, to standards more acceptable to today's residents and their families. Unfortunately, a plan has never been introduced.

With Bill 140, there's still no workable plan for the future. According to Bill 140, I may get notification by the ministry informing me if I'll get to remain open after seven years. In the absence of such notification, I can expect to be closed. That's the level of planning for capital in this act. For a long-term-care organization with an outstanding reputation that has been a model provider of long-term-care services for 40 years, this has caused a tremendous amount of uncertainty regarding our future existence.

The worst thing is, Bill 140 does not even identify what we need to do in order to keep our licence after seven years. My bank is not optimistic. My banker calls this cloud of uncertainty "risk," and he indicates that banks don't like risk. Unfortunately, I have to worry a lot about what my banker thinks, because part of our extended family's succession and transition plan for me required that I take out a mortgage. Now, because Bill 140 does not outline a workable plan for C homes, our mortgage rates have gone up—my payments have gone up considerably. There is less money in the budget to do the cosmetic upgrades and repairs to our home. But the worst thing—the absolute worst thing—is that we may not be able to renew our mortgage in four years—bottom line. Talk about uncertainty. Is it acceptable to create that type of environment in this sector?

The OLTC's proposed amendments to the licensing scheme in Bill 140 would not only address the issues I have presented, but they would give the sector back the confidence and stability to move forward with a renewal strategy that's great for the government, great for the residents and public, great for the staff and operators, and great for owners and financiers. It's a win-win.

**Ms. Kathy Dingwell:** My name is Kathy Dingwell and I work at PeopleCare, as already mentioned by Brent Gingerich. It is a good home, one that Brent should be proud of and one where all of the staff, residents and volunteers are proud to work and live.

We have had some meetings with residents, staff and families too about this legislation. Do you know that one of the biggest questions voiced by the residents is, "Why are C homes not funded to renovate to the level of the A homes or new builds?" The residents feel that they shouldn't have to move to another home to take advantage of sharing their room with only one other person. So we encourage and ask you to consider a plan that includes support and funding to allow C homes to move ahead and to renovate in keeping with today's standards.

I am also a past president of the Activity Professionals of Ontario and am currently working on the best-practices initiative for recreation in long-term care, which is funded by the Minister of Health and Long-Term Care and supported by the Commitment to Care paper. This process has confirmed something that many of us already working in the field know: Recreation programs are important, essential and a must in the delivery and provision of quality care to the residents who make long-term-care homes their home. Maslow says it best when he says that once basic needs are met, individuals can strive to meet higher needs. If you have safety, shelter and are not hungry, then you can look to fulfilling social-belonging needs or your creative needs and to achieving success.

As staff members who work in the field of recreation, it is our job to assist the residents to find other things to do: leisure pastimes of their choice that are meaningful, creative and fulfilling and which help them achieve success. Did you know that lack of activity is linked with distressed mood, frustration and problematic behaviours?

So when you come to our home, any home, wouldn't you like to see a variety of activities and recreation programs that reflect what is needed and wanted by the residents?

Currently, at our very best we would like to design programs that are structured to use the creativity and strengths of the residents that can build on these feelings of self-worth, give a sense of control as well as choice and match their interests and abilities.

Bill 140 does require homes to provide restorative care, recreational programs and social activities that meet individual-assessed resident needs. However, at our very best, with the current ratio of 1 to 60, we are able to encourage residents to attend already existing programs. We would prefer to develop programs for the individual, but how can we do this with our existing resources? Wouldn't you like to be doing something that you want to do? To do this, time is needed for assessment, planning and the implementation of programs.

**1050**

The needs of our clients are changing. They are cognitively impaired, they are young adults, they have wide age ranges—from 26 to 107 in our home. As I have said in the past and will say again, without funding to go hand in hand with these legislative changes, many long-term-care homes will have to decide how and what will be continued and what will not.

We realize and appreciate what an opportunity this is to be part of this process, but we ask you to consider not only the recommendations of the Ontario Long Term Care Association but what we have shared with you today. We ask you this not only as workers who have "worked on the floor," as we like to say, but as advocates who work daily with staff, residents, families, volunteers, community members and friends—the people who make, live and work in long-term-care homes in Ontario. Thank you.

**The Chair:** Thank you. We have about one minute per party for questions. Ms. Martel?

**Ms. Martel:** Thank you for your presentation here today. I want to focus on your banker. You've said that because the bill doesn't outline a workable plan, your mortgage rates and your payments have gone up. So even though the legislation hasn't passed, just based on what he sees, he has done those things?

**Mr. Gingerich:** That's right. As I said, bankers don't like risk. Because there's no workable plan for C homes after the seven- and 10-year fixed-term licensing, he doesn't know if he's going to get his mortgage paid off, so they have changed underwriting criteria, which negatively affects our cash flow and our ability to do the simple renovations and structural enhancements that we need to do in our home every day—not to mention that it would be completely impossible for us to upgrade to the new 1998 standards without a funding program.

**The Chair:** Ms. Smith?

**Ms. Smith:** Thank you both for being here. Kathy, we've talked about the importance of activity coordinators. You'll see in this legislation, I think for the first time, that recreation and social activities are mandated in the home. I think that's an important improvement.



I wanted to touch on what Ms. Martel was talking about with Brent for a moment, the financial uncertainty. We've heard in Kingston that OMNI has been sold. Being on the board of the OLTC, I'm sure you're familiar with Fraser and his group. He indicated that the bankers and the investors in that sector were not fussed by the legislation. That may not be his language, but he certainly indicated it hadn't affected the sale. You're probably also aware that Versa-Care is being sold and that there's been no underlying concern there, as far as we're aware, or any public discussion about concerns around the sale of that business. I'm interested to note what your reaction would be to that when you're telling us that the financial sector is jittery.

**Mr. Gingerich:** I can't speak for the speculation of some people out there in the sector, some large institutions that make moves that I don't quite understand. What I'm concerned about is our home, our sector and my ability to stay in this community. I don't want to sell to a big chain. I have no intention of selling to a large institution like OMNI has done. I don't think it's your intent in this legislation to force people to do that. I want to keep our organization in the town where it is and keep PeopleCare a family operation. What I'm saying to you is, it's very difficult for a small organization like us to finance these homes and to finance the minor—

**The Chair:** We need to move on. Thank you. Mrs. Witmer?

**Mrs. Witmer:** Thank you very much, Brent and Kathy. I know that you do give outstanding care to the residents. I am very concerned that the unintended consequence of this legislation, with its limited-term licensing, might be to force small homes like yourself—we've heard from people throughout the province of Ontario who have been in the family business for 50, 40 years, well loved in their community. People have put up with the B and C homes and the three- and four-bed ward accommodation because of the dedicated staff and everything else that happens there. It's time now that there be a plan developed in order that we get rid of those three- and four-bed wards and people have homes that are totally wheelchair-accessible.

I am very perplexed and very concerned. I don't think the government is listening. They don't hear about the uncertainty they've created for you, your residents, the people in your communities and the need to make some changes. I thank you and I regret that already your bank has recognized that you've become more of a liability than you were before the introduction of Bill 140.

**The Chair:** We're out of time. Thank you very much.

#### LUCY BUTTERY

**The Chair:** The next presentation is Lucy Buttery.

I know I've just used your name, but the procedure requires that you state your name for Hansard, please.

**Ms. Lucy Buttery:** Hi. My name is Lucy Buttery. Thank you for letting me speak. I am an SEIU member. I

work in the dietary department of a nursing home with 63 residents.

My concerns about Bill 140 are the lack of hours that we have to care for our residents. We need to put more funding into long-term-care facilities so that we can raise the hours of care to 3.5 per resident per day. At our home, we have a level of 2.03 per resident per day.

In the dietary department at our home, we have lost five hours per day since I started there 18 years ago. We currently have 0.4 hours per resident per day in the kitchen. The ministry has made many changes in our department throughout these years. Whenever inspectors come in, the rules change and more and more duties get added to our job, but our hours never increase.

The meals used to be served from the kitchen, but it was decided that the residents should see the staff serving their meals, so a portable steam table was purchased. For the last few years we've had to take the cart out into the dining room. The cart goes out at 8:30 in the morning. We used to serve breakfast with two staff, but now we do it alone. One person must serve 63 residents in 30 minutes. This is less than 30 seconds per resident. It is very important that we make the residents' meals a relaxed dining experience. In our home, it is anything but.

I have heard that in many homes, the health care aides are doing a lot of dietary's jobs. At our nursing home, they come to our cart to get the food for the tables that have residents who need to be fed, and they do our snack cart. We are expected to serve just one table, four residents, at a time: pour their tea and coffee, smile, visit, wait for them to make up their minds on what they want, and get back to our cart, all in less than two minutes. Although we know all of the residents' diets, we were just given a binder that we have to flip through to make sure that we don't give the diabetics sugar and the "dislikes eggs," etc. When we are done, we are expected to go around and see if anyone wants seconds. All of these tasks take extra time out of our day—time that we don't have. Just imagine: 63 residents brought into a dining room. Some are walking on their own, some with help. Some are getting up just seconds after they've been seated, and some have to be persuaded to go in, because they don't feel like going in at all. All of these residents are served their food, fed, and taken out of the dining room in less than an hour. Does this sound relaxing? There are bells ringing. There are staff taking residents in and out of the dining room, and running trays to the rooms for the residents who aren't coming out because they aren't feeling well.

We are run off our feet in the kitchen. Every meal is just as rushed. We have 30 minutes to serve lunch and supper. Because we have a lot more food to serve, we have two dietary staff working during these two meals. It is still quite a job because we are still expected to show each resident the main meal and the alternate and we have to be polite as we stand there and wait for them to make up their minds.

Another new thing that has been added in the last while is that we now have to chart the amount of food

and fluids that each resident has at every meal. We chart the food we use, and the health care aides do the fluid and food intake that each resident has had.

I understand the importance of all the changes that have been made in the past few years, like food presentation, which uses a lot more dishes; charting food and fluid intake; allowing the residents to have the choice of an alternate; a relaxed dining experience; and more time spent with the residents in the dining room, but each change takes a few extra minutes, and we do not have any extra time.

With the price of food, it is very hard to stay on budget, so a lot more dishes and desserts have to be made from scratch. This also takes up a lot of the dietary staff's time.

The housekeeping staff have limited time to accomplish all of their tasks as well, which leaves us kitchen staff spending a lot of time trying to keep the kitchen's cleanliness up to ministry standards.

#### 1100

When the health care aides are going to be working short on evenings, a staff member is taken off the bath shift to fill the evening shift. Sometimes they are unable to replace the bath shift, which leaves some residents not getting their bath. We had the Norwalk virus. Half of our residents were vomiting or had diarrhoea. The health care aides even had to work short one evening through this. Staff availability is just non-existent. It seems like no one wants to work in nursing homes because of the stress and workload.

The housekeeping department had to disinfect all of the doorknobs, railings and handles while the Norwalk virus was in our home. They were given an extra hour per day, but a five-hour shift was taken away so they could have that hour a day to disinfect.

The three housekeeping staff never get their work done, and a lot of days they even work through their breaks. They practically run all day long, and if a resident leaves or passes away, they are expected to clean up that room in their regularly scheduled shift without any extra time.

In the summer we get nursing students, but they only stay until they're done school and then they go elsewhere, where they can make more money and not have to run on the job.

Ours is a small facility in a small town where we often know the clients and their families. Staff try harder because of this. We want to make them comfortable. In our facility, wanderers are not segregated. When agitated or "sundowning," they will often go from room to room, which means that you end up having bell after bell ringing from cognitive residents because they are upset by being bothered. Some do not understand it is a disease; others know but they don't want these people in their space, which is understandable.

We are taught to encourage independence, to let residents do as much as possible so they don't lose their abilities. Often this is impossible. Health care aides are

rushed to get them washed, to the table and fed, all around a timetable.

If residents are ill, often the well ones are given limited attention. As an example, a resident has MS and also has a cold. She has almost no movement left in her body—maybe enough to pull the bell. Her nose is dripping but she has to wait and wait because her caregiver is busy somewhere else. Each time a little more dignity is lost. She has to be a patient woman but gets called "demanding" because she sometimes loses her temper or wants things done in a certain way, which is the only thing she has control of—all of this because she has to rely on others for total assistance. Extra hours and helpful staff would make a huge difference to help our residents maintain their dignity and quality of life.

I would like to share with you what it's like to be a resident in a nursing home, on behalf of my mother. When my mom became unable to take care of herself at home, we talked her into going into a nursing home. She was not too happy about this, but we told her that it would be better for her: Her medication would be given to her at the right times, they would give her her meals and they would help her bathe and dress. My mom was still walking with a walker with some help when she went into the home. I encouraged her to keep walking around as much as she could so that she would still be able to get around. It didn't take her very long to realize that the health care aides didn't really have the time to walk her all the way to the dining room, and that if she couldn't walk back to her room on her own she would likely stay in the dining room until it was her turn to be taken back. She realized that if she had a wheelchair she could get back and forth on her own, so we bought her a wheelchair. It wasn't too long before she didn't use her walker at all.

My mom went into the dining room for every meal. After every meal, the girls would take her back to her room, they would help her to the bathroom and put her into her La-Z-Boy chair. She would usually stay there until the next meal. The health care aides would bring her a drink or a snack off the snack cart at 10, at 2:30 and at 7 o'clock at night. She never dared to ask for too much because she knew that the girls were too busy and she didn't want to bother them. The health care aides never told my mom when they were working short, but she always knew because they were always in that extra big hurry to get her done. In the morning they would put my mom on the commode. Sometimes they would have problems in another room with another resident and they wouldn't get back to her for 10 or 15 minutes. She would tell me about it, and to her, it always felt like it was an hour. Imagine how helpless you would feel.

Like most seniors, my mother was very set in her ways and she did not like change at all. She suffered from osteoporosis and needed help getting dressed. Before she went to the home, she always liked to wear a buttoned-up shirt, a straight-cut skirt, a slip, pantyhose and a girdle. After about two days of living in the home, the staff were at her about not wearing her girdle because



it took too long for them to put it on her and they didn't have time. She was pretty stubborn about this and would not hear of it, so she started at the family about it. After about two months, they finally just stopped putting it on her. I think that's when my mom finally realized that her independence was really gone. Next came the pantyhose. The girls just didn't have the time to struggle to try to get them on her. My mother was 86 years old and for the first time in 60 years she had to wear socks and jogging pants instead of pantyhose. To anyone else, this might seem like a minor thing, but it was a really big deal to my mom. This was one thing that always really upset her.

There were a few things that my mother just wouldn't give in on, like wearing her housecoat to the dining room so she would be ready for her bath right after breakfast; going to bed early because the health care aides started at the end of the hall and did one room at a time so they could get them all into bed before 9 o'clock, when one of the shifts would end. That meant that she would have to go to bed shortly after 8. Some staff approached me about buying mom some open-back nightgowns. They said that it would be much faster and much easier for them to change her. The next time the clothing company came to the home, I took mom to look at them. She wouldn't even look at them, but I bought her two, thinking that I would talk her into it later. After my mother passed away, I found the nightgowns in one of her dressers. They had never been worn.

Wandering residents were always a problem. They would just come into her room at all hours of the day and night and get into her belongings. This was very upsetting to her. There was just not enough staff to keep an eye on all of these residents. When any of our family members complained about this, they would tell her to keep her door shut, but my mom was afraid of being locked in a room all by herself. They put a six-inch-wide yellow band across her doorway. This didn't really work, but it was the best they could do for her. She spent many nights being afraid.

My mom was really lucky to have a big family who visited her a lot, and the staff from the activity department did their best to try to talk her into coming out to their activities. I see so many residents who have little or no family. It makes me feel very sad to think of how long their days must be, alone in their rooms with staff rushing in and rushing out to give them care, and push them back and forth to the dining room for their meals in a hurry because they have to get all 63 residents there in 10 minutes. No one has any extra time to just stop by and say to them, "How are you today? Is there anything I can do for you?" or "Would you like to go for a walk?" because we are all so busy trying to do our jobs and stay caught up on all our charting.

Current regulations require documentation and charting. This takes time away from staff being able to provide more hands-on hands. If the government wants more accountability, then they need to provide more money for staffing to complete documentation for the accountability. As the saying goes, if you don't chart, you haven't done it. By the time you get your work done

properly there is no time left to chart. It's always a balancing act. Which is more important—the resident or the charting?

Because we are a small facility, it is often difficult to obtain staff. Part-time hours are shorter and staff often work two jobs to make a living. Young people do not want to stay working in this environment long-term. After working in this kind of atmosphere, you just get tired, your patience runs thin and it is very hard to stay focused on why you really chose to work in a long-term-care facility.

**The Chair:** One minute, please.

**Ms. Buttery:** It is getting harder and harder to find anyone who wants to spend the rest of their career being a health care aide or a dietary aide in a long-term-care facility because the load is just too heavy. This is why so many homes have to work short. There is just no one to hire. It is our job as health care providers to give our residents the best care possible. Please help us help the residents.

**The Chair:** Thank you. There is no time for questions.

1110

## ONTARIO RETIREMENT COMMUNITIES ASSOCIATION

**The Chair:** The next presenter is the Ontario Retirement Communities Association, if you would state your name. Those who have an agenda—I believe that Gord White is replacing the initial presenter.

**Mr. Gord White:** Yes, obviously I'm not Shelley Gould. I'm Gord White, CEO of the Ontario Retirement Communities Association. What I'd prefer to do today is make a very brief presentation on the one point that we have to make and leave some time to respond to questions. The issue we have, and you may want to turn to this page in the act, is with subsection 93(1). I'll explain a little bit about the retirement home sector. I really did not imagine that in the course of my responsibilities with the association I would end up speaking at a forum such as this, dealing with long-term-care homes. But subsection 93(1) requires that I be here today.

The retirement home sector in Ontario is about 38,000 beds across the province. It is a sector that also provides care and accommodations for seniors, but one where seniors pay 100% for the care and accommodations. Representing the Ontario Retirement Communities Association, we represent 60% of those 38,000 beds, so it's about 23,000 beds across the province that are members of our association. The principal role with our association is to be an accrediting body for the sector. We set standards, we inspect and we accredit retirement homes. Only retirement homes that have passed our accreditation and continue to meet our standards are allowed to be members in our association.

I've defined the sector a little bit and, if we're talking about numbers of beds, it's about half the size of the long-term-care sector in Ontario at the moment.

Now to the point: What brings me here today is subsection 93(1), and in that it says, "No person shall operate residential premises for persons requiring nursing care or in which nursing care is provided to two or more unrelated persons except under the authority of a licence under this part or an approval under part VIII." So it's an issue of the provision of nursing care and whether or not to license. The way this is written, it looks to our association and to operators of retirement homes in Ontario as if retirement homes would no longer be able to provide nursing care, depending on what the definition of what nursing care is. If it were to mean the distribution of medication, that would include just about everybody living in a retirement home in Ontario today. I would say that all 38,000 people living in retirement homes receive some sort of nursing care, and that's a primary driver for people wanting to live in a retirement home. So if we were to read this act in this way, it would suggest that if retirement homes were not licensed or given some sort of exception, then people living in retirement homes would be required to find their care elsewhere, and probably the only place they could find their care would be at long-term-care homes. It doesn't seem to make sense.

We would like to see as a solution to this problem that retirement homes be considered as an exemption, and that would appear under 93, and there's room for an exemption here under clause 93(2)(b). Under that is an allowance for other premises to be exempted from subsection 93(1). That's the point. Essentially, we're saying that if the province wants to have an act that's regulating care in retirement homes, that's another solution; there should be a specific act to get to that outcome to regulate care in retirement homes. It really shouldn't be done under 93(1). And, by the way, in our conversations with the province on this issue, the general response we've had each time is, "That's really not the intent of subsection 93(1)." We understand that. My purpose today is, I guess, to reiterate that point, to bring attention to it and to make sure that it is not an outcome that 38,000 people would no longer be allowed to receive care.

With respect to an act regulating care in retirement homes, the province has initiated a process to begin that. As a matter of fact, next week public consultations to discuss the issue of providing a regulatory framework for retirement homes begins in Sudbury. I believe there are 13 stops around the province. That's something that we are supportive of as an association and something that we are looking forward to. I believe I've made my point. I'll take questions.

**The Chair:** Good. We have eight minutes for questions. Ms. Smith.

**Ms. Smith:** Mr. Chair, you'll be delighted to know that I won't even take my share of the eight.

Gord, we've had a chance to discuss this previously. As you mentioned, there is a consultation going on. There's also a consultation backgrounder, a white paper, that has been sent out to various stakeholders, including a questionnaire. People are being asked for their points of view. The 13 consultations start next Tuesday in Sudbury

and are going to Thunder Bay, Windsor, London, Kitchener-Waterloo, Toronto, St. Catharines, Hamilton, Ottawa in both French and English, Kingston, Barrie and Brampton. From what I understand, these are working group discussions on looking at the retirement home industry and how we can best regulate it.

As we discussed, section 93 is actually what already exists in our long-term-care home legislation. It was determined that we would stay with the status quo until the consultation on the retirement home sector is complete and that clause 93(2)(b) gives us the regulation-making ability to address whatever come out of the consultation. We don't want to prejudge what happens in the consultation, so we've given ourselves the ability through that regulation-making authority to address your concerns. I thank you for bringing them forward today. I think that we'll be able to address this once that consultation is complete.

**The Chair:** Mr. Hardeman.

**Mr. Hardeman:** Thank you very much for the presentation. I appreciate the comments from the parliamentary assistant, recognizing that we do have an answer for the question. As I looked at the section when you started your presentation, I too would have concerns. I want to quickly go just one step further, beyond the consultations that are presently going on, not prejudging what those consultations will direct. Your suggestion of an amendment for an exemption: If there is not a regulatory regime put in place for retirement homes—I suppose one always has to remember that consultation could lead to any conclusion if it's full and open consultation—if there is no act coming forward with an exemption to this, how would you identify retirement homes as being exempt? How would you suggest that that be done?

**Mr. White:** That's an excellent question. It's very difficult to identify retirement homes without having a definition set in legislation. Retirement homes are covered under the "care homes" section of the current Tenant Protection Act, which we know is going to be the Residential Tenancies Act at the end of this month, but really that's a fairly broad net that's covering retirement homes, plus other types of housing. So it would be difficult, I think, to use "care homes" as a definition to really meet our need. That is a concern for our association.

**Mr. Hardeman:** In going on, then, you just mentioned care homes. Would the exemption you're suggesting that you could put in as number 5 in the list of exemptions then also include care homes?

**Mr. White:** No. I'm certainly only here to speak to the issues that are facing retirement homes. "Care homes" is really a very broad definition and it's covering different types of housing. It's also including rooming houses and boarding lodges and things like that with things that really aren't dealing specifically with seniors in the type of environment that they experience in a retirement home.

**Mr. Hardeman:** I'm just trying to get it straight here. Wouldn't care homes also be covered in this section and have the same problem as retirement homes?



**Mr. White:** At the moment, I guess a care home, if there was no legislation that was really affecting this sort of specific—probably could be affected by this particular act the way it is written.

**Mr. Hardeman:** So it's reasonable to assume that not only should government be looking at whether there should be an exemption for different accommodations, including retirement homes and care homes and so forth, even if the legislation on retirement homes comes forward to legislate retirement homes, something more needs to be done for some of these others because this is quite prescriptive.

**Mr. White:** Correct. I would presume that if "care homes" were to be applied to retirement homes, it would also be applied to other homes that are covered under the "care homes" section.

**Mr. Hardeman:** Thank you very much.

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**The Chair:** Ms. Martel?

**Ms. Martel:** Thank you for being here today and for bringing this to our attention.

The conversations that you've had with the ministry about this: Have they been verbal conversations to say that retirement homes are not included?

**Mr. White:** Essentially, it's indicated that retirement homes could be dealt with as a possible exemption under the regulations, and there certainly is room in the legislation for that to happen. The trick is, if there's no act defining what a retirement home is, how do we get into that exemption? Certainly it's not in anyone's best interests across Ontario to preclude the provision of care in retirement homes.

**Ms. Martel:** You've heard what the parliamentary assistant has had to say. Does that respond to your concerns?

**Mr. White:** It's close to responding to our concerns, and it certainly makes our membership feel a bit more confident, yes.

**Ms. Martel:** So perhaps if you could get something in writing from the ministry to reinforce what she has said and that you could give to your members, that would be helpful.

**Ms. White:** Of course, we would look favourably upon that, yes.

**Ms. Martel:** Perhaps we'll make that suggestion to the ministry or to the parliamentary assistant as a follow-up: putting something in writing that can be shared with members of your association so that everyone understands the rules under which we're operating right now and that you're not affected.

**Mr. White:** Right. Thank you.

**The Chair:** Thank you.

#### COUNTY OF ESSEX

**The Chair:** We move now to the county of Essex.

Welcome. If you would state your names for Hansard, please.

**Mr. Brian Gregg:** Thank you, Mr. Chair and members of the standing committee on social policy. We represent the county of Essex, which owns and operates the Sun Parlor Home and the Victoria Street Manor. I am Brian Gregg, chief administrative officer for the county of Essex, and with me is Bill MacDonald, the administrator of both homes. We appreciate the opportunity to be here this morning and offer comments on this important legislation.

For over 100 years, the Sun Parlor Home, located in Leamington, has proudly offered its services to the community of Essex county. As a not-for-profit long-term-care home, municipally owned and subsidized by the county of Essex, all our resources are dedicated to the residents. County ratepayers currently contribute more than \$5 million towards the operation of our two facilities.

Our mission statement is, "To serve our community, providing supportive resident-focused care that promotes quality of life." This pertains to the 206 long-term-care beds at the Sun Parlor Home, as well as 14 beds in our supportive housing group home, the Victoria Street Manor, which operates in Amherstburg.

We believe that the quality of life, safety and well-being of long-term-care-home residents in Ontario is a priority, and we demonstrate this by providing excellent-quality care to our residents which continually exceeds minimum standards. We also believe that all agencies, profit and not-for-profit, must be accountable for the care and services they provide. To this end, the county of Essex supports the spirit of Bill 140.

Essex county does wholeheartedly endorse the government's goal of building a strong, accountable and resident-centred long-term-care system. We also feel that our home is there to serve our community, and has been doing so for many years now. We can understand the desire to consolidate the three existing pieces of legislation into one. The goal of adequately training all contracted staff and volunteers is generally supported.

There are, however, many measures in the proposed legislation that we believe have no direct impact on our residents' quality of life, safety or well-being. We are also greatly concerned from a municipal perspective about the tone of the legislation, which is more punitive and prescriptive in nature. We understand the need to address the small percentage of poor performers in our industry. However, we believe that the great percentage of homes that exceed the minimum ministry standards, particularly through municipal and charitable assistance, should be recognized and rewarded for doing so. In this manner, we are more likely to achieve the desirable "home" environment. Accordingly, it is important that we get the legislation right at the outset, as it will affect the lives of our residents in long-term-care homes for many years to come.

The warden of Essex county wrote to the Minister of Health on November 29, 2006, regarding Bill 140. In that letter, we endorsed the positions taken by the Association of Municipalities of Ontario, AMO, and the Ontario

Association of Non-Profit Homes and Services for Seniors, OANHSS. The purpose of our presentation today is to further elaborate on these issues. We know the committee will be hearing much more from our associations about their detailed recommendations to alter the act.

I wish to turn the presentation over to Bill MacDonald, the administrator of Sun Parlor Home, to present in our own way some particular concerns.

**Mr. Bill MacDonald:** We have six concerns, the first being doing more without the resources to do so. The legislation does propose to do more in a number of ways: more documentation, more compliance, more administrative requirements, etc., all of which we believe would shift resources from where they are needed most—at the bedside.

Municipalities have seen both increasing complexity of resident care needs and the cost of new standards without the corresponding provincial funding support for many years now. The legislation changes the government's funding obligation from "shall" to "may" fund our requirements. We are concerned that this ambiguity may, in the future, provide the ministry with the legislative authority to further erode funding envelopes. The government's pre-election commitment to increase operating funding to \$6,000 per resident is only one third achieved prior to these new legislated requirements. If left unaddressed, this results in another downloading of funding responsibility to the municipal sector and/or redirecting funds from resident care needs.

Our second concern is not-for-profit support. In many ways and in many places the current government has, in words, supported the not-for-profit health care delivery model. It is disappointing then that there is no strong and explicit statement in this legislation's preamble. We believe that the government should commit to preserving and promoting the not-for-profit long-term-care sector by means of an explicit statement. We feel that this is appropriate given that 65% of the new 20,000 long-term-care beds in Ontario were awarded to the for-profit sector.

Our third concern is about the personal liability for directors. Essex county council is greatly concerned with the increased personal liability proposed for directors for failing to take all reasonable care to ensure their homes meet all requirements of the act. The implications of this appear to be particularly harsh, especially when compared with other legislation, such as that governing hospitals and the new LHINs. One of our councillors did ask whether the minister would be subjected to the same personal liability exposure. Why such a heavy-handed approach is necessary for municipalities that have shown leadership and significant contribution in the provision of long-term care in Ontario is a mystery to us.

Our fourth concern relates to individual rights versus collective rights of all residents, which is best illustrated in this question of secure units. We welcomed the review of long-term care done by Monique Smith—we mean that sincerely. It emphasized that we are homes where

residents are partners in care to be treated with dignity and respect. At the Sun Parlor Home, we have certainly taken pride in doing precisely that. We have also taken great care to balance the needs and rights of individual residents with those needs and rights of all residents.

Thus, the sections referring to secure units are of particular concern. We do support minimizing the use of restraints throughout the home and in secure units. We understand that in our secure unit residents can have forms of dementia and other behavioural difficulties which may present safety risks not only to themselves but to other residents and staff. We need to be able to provide the special care that these residents need.

So section 43, relating to the CCAC's authority for admission to these secure units, seems to define these special-care units as a restraint. Applicants may need a special-care unit, but may not be able to place the resident in one because the substitute decision-maker has not consented to this placement. This would present a risk to all other residents throughout the home. As a result, homes may be eliminating secure units entirely rather than present such a risk to so many other residents. These matters are particularly sensitive in all homes, as we await the government's actions arising from the recommendations of the jury in the Casa Verde nursing home inquest.

#### 1130

Our fifth concern is related to capital funding. We realize the ongoing need to maintain and upgrade the physical plant in our homes and have done so in Essex county. We take exception to having no legislated funding obligation on the part of the province to assist us in doing so. In particular, section 133, which can order renovations without any reference to funding assistance, is troubling. There should be commitment by government to a capital renewal strategy.

Our sixth concern is funding for training. As we did state earlier, we do feel it appropriate that orientation and training for all contracted staff and volunteers be conducted. Generally, we feel that homes can do more to serve the needs of our elderly residents if our staff are appropriately trained. However, again, we must state with some dismay the lack of government funding to do so. These requirements, along with numerous others, as legislated and negotiated, are creating a burden on municipalities which is becoming increasingly difficult to absorb.

I would like to turn it back to Mr. Gregg for our concluding remarks.

**Mr. Gregg:** As stated in the warden's letter to the minister that we referenced earlier, we do strongly support AMO and OANHSS, who have eloquently stated the following:

"The not-for-profit sector has a long and proud history of 'going the extra mile' for the residents—providing more than is required, topping up provincial funding with municipal and charitable contributions, creating home-like environments, serving the distinct needs of our communities, and working closely with local volunteers.



"We want to continue to play a leadership role in providing quality care, and we want to work with government to make lasting improvements to the system. Unfortunately, Bill 140, as it is now drafted, does not encourage a true partnership between providers and the government. The bill is adversarial in nature, and it places almost all of the obligations on the homes."

Thank you for the opportunity to present these concerns to the committee. We look forward to seeing these addressed in further iterations of Bill 140. In particular, we ask that you pay close attention to the detailed recommendations being provided to the committee by OANHSS and AMO during this consultation process.

We in Essex county continue to be committed to the provision of long-term care to our most frail and vulnerable residents in a spirit of true partnership with the province of Ontario.

**The Chair:** Thank you. There are about two minutes for questions, starting with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation and for the care that you provide to your residents. You say that the legislation is going to mean more documentation, more compliance, more administrative requirements, which means less money available at the bedside. I wonder if you could articulate for us what impact that is going to have on the level of personal care.

**Mr. MacDonald:** Thank you for the question. First, I would say that our industry is one of the most highly regulated, highly accountable industries in the health care sector. We sign a facility service agreement each year which basically commits us to live up to every single standard—even standards that haven't been thought of yet, which is kind of hard to do. So all of the additional requirements of the legislation, albeit well-intended or not—it's really about resourcing them. If the county didn't contribute to our organization to pay for those extras, then it would come from the bedside, and it's a difficult equation to say precisely when the county has had enough. But in reality every single administrative extra, even the training, which we welcome—it's a good idea to train our consultants and volunteers, but it's an extra. It all requires more and, if not resourced, it will take away from the bedside.

**Mrs. Witmer:** I guess you are in a fortunate position—I say "fortunate" because you've got taxpayers who can—but we have many homes throughout the province who are going to be subject to the same documentation and what have you, and obviously there is no taxpayer there able and willing to help, so that is of real concern. I guess the bottom line is that if you're going to impose this onerous documentation and administrative workload, you need the resources—financial and human.

**The Chair:** We need to move on. Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I acknowledge that's a very significant contribution by the taxpayers and the county to support these two homes.

I just wanted to focus on the two concerns you raised: one with respect to secure units, the second with respect

to an order around capital funding. Can you just give me a sense of what you'd like to see in those two sections that might minimize or take away your concerns?

**Mr. MacDonald:** Let me start with the second and say that the ministry has had support for capital funding and a fund to keep facilities up to date, and I think a continuation of that type of capital funding support will keep even the brand new homes up to the standards that we'd like to see. That's the kind of capital funding commitment that we have in mind.

With respect to the secure units, that's a different question, and it does relate to a rather tricky, for those who aren't in the business—but the idea of treating the secure unit as a restraint and thus requiring this consent. If a resident who needs to be in the secure unit doesn't have that consent, all of a sudden throughout the home this does create quite a hazard. You're probably well aware of the deaths that occurred in the Casa Verde nursing home. This is the type of aggressive resident that we need to treat properly and put in the appropriate place in this province. So that's a slightly different challenge.

**The Chair:** Thank you. Ms. Smith.

**Ms. Smith:** I just want to follow up on Ms. Martel's point. I recognize that it is definitely a challenge and we do have a variety of behavioural issues in our homes, but putting someone in a secure unit, albeit for their safety or the safety of all the other residents, does mean limiting their movement. The secure unit means that they are not given the pass code and not allowed to leave. That's a pretty big decision to make, and I know it's not made lightly in our homes. We have heard from family members, the Alzheimer Society, the Advocacy Centre for the Elderly, that they really feel that consent is necessary in order to take away that right to mobility. I think you're suggesting here that you don't believe we should be seeking a consent from the resident or their substitute decision-maker to move into a secure unit. Is that what you're proposing?

**Mr. MacDonald:** Obviously Monique is very knowledgeable and presents both sides of the argument very well. Having participated with OANHSS, our association, and the ministry in looking at this very challenging question of where are the most aggressive and the most difficult forms of dementia best handled so that we look after the needs of that resident as well as the needs of all our other frail and elderly residents, I would say that it's a challenge. There are examples of good secure units in this province today that are doing precisely that, but they also are resourced to do so. They're designed and resourced to do it a little bit differently.

We may have opportunities in our province. We're about to open up some new homes, even in the Windsor-Essex area; thank you for acknowledging that. There may be opportunities to create units that are designed to truly house these residents. Frankly, today there's not a good spot throughout our entire health system to put them in. It has been a challenge in prior governments and a challenge in the current government, and we need to do something about it. It's probably the single biggest chal-

lenge the industry has. So there may be some opportunities.

**Ms. Smith:** Absolutely, and I know that there are discussions ongoing about that.

If I can sneak one quick one in, you said that there should be a recognition of good homes. Short of more funding—and I put the same point to the chair of Belvedere Heights in Parry Sound yesterday—do you have any quick suggestions on how we could recognize good homes?

**The Chair:** Really quick suggestions.

**Mr. MacDonald:** One quick one: In the accreditation process that health facilities are subjected to voluntarily, if you're a good performer, they only come around every three years, and if you need them to come around every year because you're average or less than average, they come around every year. I understand that's being considered. So that's a small form of reward that would recognize the good performance of some homes.

**The Chair:** Thank you.

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#### JOHN VAN BEEK

**The Chair:** The next presentation scheduled is by Margaret McClintock. We've been advised that she's unable to make it today, but John Van Beek has requested that he make a very short statement on her behalf. The Chair has ruled that that's acceptable; if the committee doesn't concur, I will probably storm out in a huff.

**Mr. John Van Beek:** Thank you very much. I'm going to be very brief, so it will put you back on schedule.

Nursing home workers who have made presentations here have been under the gun. They are very nervous, of course, in terms of presenting in front of this committee. I was informed late last night that a letter had been sent to one of our members who was going to make a presentation, and I just want to read the letter and put it on record. Of course, we will take the appropriate action. This is dated January 23, 2007.

"Ms. Marg McClintock

"c/o Caressant Care on Mary Bucke," which happens to be in St. Thomas.

"Dear Ms. McClintock:

"It has been brought to our attention that you will be speaking at the Bill 140 London public hearings meeting on Wednesday, January 24, 2007 at 11:30 a.m.

"This letter is to notify you that during this meeting you will in no way be representing Caressant Care Nursing and Retirement Homes Ltd. in your opinions and outlooks.

"If Caressant Care determines that you have represented them in any way, this could lead to your termination of employment.

"Sincerely,

"Cheryl MacDonald

"Manager, Human Resources," from their corporate offices in Woodstock.

It's a deplorable situation, of course. The union will attempt to correct this situation in terms of the ability of threatening people's right to speak out. In terms of that, it's just absolutely deplorable. I just want to put that on the record. Thank you.

#### CANADIAN UNION OF PUBLIC EMPLOYEES

**The Chair:** The next presentation is Pat Riedel.

**Mrs. Witmer:** I guess I have to ask why someone was able to make a presentation without being on the list of speakers. I do know that there are other people in the audience who actually spoke to me today and indicated that they would appreciate the opportunity to speak. So I don't know that we can arbitrarily allow different individuals to speak, at the whim or will of whom, but I think there has to be some fairness. There are other people who also would like to get on the record.

**The Chair:** The reason I concurred with the request was that the gentleman was speaking on behalf of someone who in fact had registered and had been assigned 15 minutes. If I erred, I apologize for that. But it was on her behalf and I accepted the request.

Would you state your names for Hansard, please.

**Ms. Pat Riedel:** Pat Riedel. Good morning. I am currently the area 1 representative for the health care workers coordinating committee of the Canadian Union of Public Employees, or what is known as CUPE.

I've worked as a health care aide in a municipally funded long-term-care setting for 30 years, 25 of which have been full-time, five days a week, every week, and I can attest to the fact that there have been a lot of changes in long-term care and not a whole lot of them have been positive. Just so you're aware, CUPE represents 24,000 members working in approximately 217 long-term-care facilities across the province of Ontario.

One of the key areas of concern that we have regarding this bill centres around the issue of staffing. Staffing levels in homes, and the one in which I work, can vary and, depending on the shift you work, the staffing ratios can change from as much as 12 to 1 and in some cases they can go as high as 30 to 1 or 35 to 1, depending on your shift. The midnight shift is usually the one that is least covered.

Research has shown that staffing levels in privately owned or for-profit homes have a much higher resident-to-staff ratio, as more staff ultimately means a lower profit margin for the home. A regulated minimum standard of 3.5 industry-wide would go a long way toward changing that problem. The legislation in Bill 140 fails to set out a minimum standard for resident care. A minimum level of 3.5 hours of hands-on care for each resident in all homes must be included in the legislation. Alberta already has 3.5 hours of care as their minimum, and New Brunswick and Saskatchewan are working toward achieving the same. I'd like to know why we're not, here in Ontario.



Staff changes and working short-staffed have become an almost expected part of our jobs. This is a chronic problem and is prevalent across the province. Employers are not always concerned about replacing staff who have booked off. Why would they be? They know that the staff who remain there are going to work their butts off to make sure that the work gets done and the residents get cared for because they care very deeply about these residents. Some of them are not just clients; some of them, who have no family, become family to us and we become family to them. So you're not going to allow that person not to be washed, not to be dressed, not to be fed because you're working short; you're going to do that. In the interim, the employer is saving the wages of this employee they have not replaced.

Residents have been mandated to have two baths a week. When you're working short, you have to decide what it is that you're going to give up, and quite often it's that resident's second bath. You have no idea how much it hurts a staff member to have to walk into a room and say to a resident, "I'm sorry, but you're not going to get your bath today because we're working short and I don't have the time to do it." It's the same if they ask you to do them a favour and you have to tell them, "I don't have the time right now. Maybe I'll get to it later," and you don't get to it, and you go home at night and you think, "I should have done that." It's too late by that point in time.

The other issue that's not addressed in this bill is violence in the workplace, and I'm not talking about violence just against staff. The problem the staff have, when they're working in a unit such as an Alzheimer's unit, is with residents who are suffering from some form of dementia or possibly brain damage. What happens is that quite often, because they are confused and unable to rationalize properly, they will strike out at you. I can tell you from experience that every time this happened to me—and I worked in an Alzheimer's unit for 25 years. Each and every time this happened to you, you were told by your employer, "What are you complaining about? It was part of the job. You knew it was part of the job when you took the job." When it happens, the first question out of their mouth is not, "What happened?" It's, "What did you do to provoke it?" We need to have more staff in the homes in order to protect not only our residents but our staff as well.

Part of the problem that we have as well nowadays—when I first started working in long-term care, the majority of the residents we had could do at least part of their own care. Now they're being kept in the home longer, and they're coming in requiring a lot more hands-on care and a lot more time, and we just don't have it to give with the staffing levels that we have at this point in time. We've been finding as well that, because of the closure of mental health facilities and facilities that used to handle the mentally challenged or developmentally challenged, we're getting those people in our homes, and it's a totally inappropriate setting for these kinds of people. They're put into the general population, with frail and elderly residents who cannot defend themselves.

1150

The timing for the gentleman who came before me to read the letter regarding the staff member who was told she would be terminated if she came here was almost a godsend. When it comes to the whistle-blower protection that's in this legislation, it's practically nonexistent. I think you've seen a perfect example this morning of what can happen if you make an attempt to report any kind of abuse or any problems within your facility. What happened this morning is a perfect example. The employers in the homes make it very well known that there is a process to go through to report abuse or suspected abuse or problems within the home. But what happens is that, even though the information is on the forms, quite often you can't get those forms unless you go to your employer and ask for them. This means that they know exactly who made the report, and you are then subject to disciplinary action up to and including termination, such as what this woman was just threatened with.

One of our other concerns is the fact that there were only four cities in the entire province that were given the opportunity to speak to this bill. Those were Toronto, Kingston, Sudbury and London. This effectively cuts out at least 73 groups we know of that have had no opportunity to address this issue. I do believe that it is necessary to demand that there be more hearings in more communities.

Our elderly citizens deserve better. They deserve to be treated with dignity and respect. All of us must realize that in the coming years we are probably going to be in that situation. Funding for homes affects not only the residents in the home; it's going to affect every member of our community at some point, because at some point we may very well find ourselves in the same boat.

What I find is happening in the homes, because we don't have the hands in the house, is that we're not able to get things done. I can fully sympathize with the woman who was up here before, talking about the dietary things. It's not just nursing departments, but every department is working short.

I want to be very clear on where this 3.5 hours that we're asking for is supposed to go. I understand that during some of the other hearings in some other areas, there was some confusion on what the 3.5 hours and the funding for that would go to. That is specifically for hands-on care: for RNs, RPNs and health care aides. That's for the people who do the washing, the dressing, the actual physical hands-on care.

I understand that there was some confusion. They were questioning whether or not this was to increase maintenance, the dietary departments and that kind of thing. I'm not saying that those departments are not important. I'm simply saying that I want it to be very clear that when we're asking for 3.5 hours, that is specifically for front-line workers and hands-on care. Thank you.

**The Chair:** We have about four minutes for questions. Ms. Martel.

**Ms. Martel:** Thank you for your presentation. You've spent 25 years working with—

**Ms. Riedel:** No, actually 30 years working; 25 were full-time.

**Ms. Martel:** Full-time for 25 years, but 25 years working with patients suffering from Alzheimer's. Is that correct?

**Ms. Riedel:** Actually, I did over 26 years on an Alzheimer's unit. It's only been in the last four that I have not been, and that's only because the employer has restructured our workplace and has done away with 20 Alzheimer's beds in our facility. We now only have one locked unit that addresses Alzheimer's clients. The other 20 were put back into what is commonly called ambulatory or independent care, which means that you have to be able to pretty much come and go on your own and be able to find your own room and your way around the home in order to be there. What's happening, not necessarily in my home, but because of the lack of beds for the cognitively impaired, is that they're ending up having to put them into the general population, and what happens there is that your frail elderly then become victims when these people have their episodes of violence, and you don't always have the staff to stop that.

**Ms. Martel:** How many of the staff have received training to deal with people with dementia?

**Ms. Riedel:** That's the problem: A lot of them don't. They are downloading people who have been in psychiatric institutions, who have a developmental problem. They are putting these people into the homes, but they are not providing any kind of training to the staff for them to know how to deal with them. This increases not only the possibility—the probability, rather—that a resident can be harmed, but staff can be harmed, because they don't know specifically how to deal with or defuse a specific situation.

When a resident—believe me, I've worked in Alzheimer's units for a long time, and when a resident looks at you, you know that he's going to hit you. A lot of the times you don't have that kind of warning with people—

**The Chair:** We need to move on.

**Ms. Riedel:** —who have psychological disorders. At least with an Alzheimer's client, you have some indication of warning, whether it be a change in the facial expression or the eyes.

**The Chair:** Ms. Smith?

**Ms. Smith:** Thank you for your presentation. There are a few things I just wanted to address.

Alberta has set a target of 3.5, but they actually don't have a minimum standard of 3.5. They do say that they're funding to 3.5, but there is no documentary evidence to that effect. As well, we don't have any Canadian jurisdictions that have a legislated minimum of 3.5.

I did want to ask you, though, about the 3.5. You say you would include the RN, RPN, health care aides, those doing bathing and dressing. If there were particular individuals in the home who were assisting with feeding, would you include that in your front-line, hands-on care?

**Ms. Riedel:** Feeding is specifically a health care aide function in the home that I work in. It's not dietary or anyone else.

**Ms. Smith:** In your home. But in other homes, they sometimes have them as different types of staff. I'm just saying, if within a home there were someone assisting with feeding, would you include that in your definition of hands-on care?

**Ms. Riedel:** That depends on whether they were staff or whether they were volunteers. You need to be a little more specific about "someone else" in order for me to answer that.

**The Chair:** We're out of time. Mr. Hardeman?

**Mr. Hardeman:** Thank you very much for the presentation. I too wanted to go a little bit into the 3.5 and who was included. We've had a number of concerns in my community where different homes have calculations as to what standard they're providing and then who is included in dividing the number of hours that are available to the number of patients in the facility, what standard we are meeting in doing that. I think it's very important to understand how you perceive the calculation needs to be done in order to say, regardless of whether it's 2.5 or 3.5, how you calculate and who you include in the calculation as to hours of care available per resident.

**Ms. Riedel:** The way we have done the calculation that you're talking about was, we were counting in how many RNs, how many RPNs, and how many health care aides we have within the home on each shift. You take the number of hours that are allotted to those people, how much they're actually paid for, and you add them all together and divide them by the number of residents that you have in your home. That should give you a fairly good idea of what the hours of care are that are available to the resident in that home. In—

**The Chair:** I'm sorry; we're out of time.

**Ms. Riedel:** In the one that I work in, that's actually 2.7 hours, not 3.5.

**The Chair:** Thank you very much.

Just some housekeeping: The committee will be meeting in the Manchester Room for lunch.

This room will be cleared and locked over the noon hour, so if you have possessions that you wish to have access to between 12 and 1, if you would take them with you.

The committee now stands recessed until 1 o'clock.

*The committee recessed from 1200 to 1301.*

**The Chair:** The committee is back in session. For those of you who are joining us this afternoon, each presentation will be a maximum of 15 minutes. Any time left over after you present is utilized for questions from the members of the committee. I would ask that when you come to your chair if you would state your name for the purposes of Hansard.

#### PARKVIEW NURSING CENTRE

**The Chair:** The first presentation is by Parkview Nursing Centre in Hamilton.

Welcome.

**Mr. Kevin Baglole:** I want to begin by thanking the committee for permitting me to present to you today.



**The Chair:** I don't know why, but the procedure requires that you state your name.

**Mr. Baglole:** That's my next sentence.

**The Chair:** I apologize. I will give you 20 extra seconds.

**Mr. Baglole:** My name is Kevin J. Baglole. I'm the administrator of Parkview Nursing Centre in Hamilton. Prior to taking on this role, I had the privilege of serving as the coordinator of pastoral care and social services in three long-term-care residences in Hamilton since 2002. Prior to that time, I was involved as a volunteer committee member and faith group representative in a number of long-term-care homes, first in Kitchener-Waterloo and then in south Niagara. I have a large concern for seniors in general, and specifically the health and well-being of the frail elderly living in long-term care.

When I review and read Bill 140 and consider its implications for all those involved in long-term care, especially our residents, I have a deep concern for what impact the various components of the bill will have on the spirits of those involved. I wonder if the uncertainty of the licensing renewal will impact the spirit of the residents, who may not know what their future holds. When hope, security and certainty are removed, the human spirit is unsettled and can become fearful. I wonder if the families of residents, who have placed them in a home to be cared for, will have disturbed spirits, because instead of caring for residents, staff might be required to complete onerous amounts of paperwork in order to satisfy compliance standards. I wonder too about the spirit of the front-line staff members who are faced with more and more complicated care issues of residents but do not have adequate support from additional staff to assist when most needed. I wonder about the spirit of the entire long-term-care sector, as it seems that instead of being committed to delivering the components of a life of quality to our residents, Bill 140 seems to create a spirit of suspicion, over-supervision and fear of non-compliance.

I am certain and I know that those who were involved in drafting this bill did not intend to harm those involved in long-term care, but I encourage the members of this committee to use this opportunity of sober second thought to point out the shortcomings and burdensome aspects of this bill that require change. We need to seize this opportunity to create a spirit of co-operation in putting the tools in place to enable all of us to build a life of quality for our residents.

But I want the committee to hear from one who is deeply involved in long-term care. To that end, today I'm accompanied by Mrs. Arlene Fitzpatrick from the family council of Parkview Nursing Centre. I will permit her now to outline her concerns and requests to you.

**Mrs. Arlene Fitzpatrick:** Thank you, Kevin. My name is Arlene Fitzpatrick from Parkview Nursing Centre in west Hamilton. I set up our family council and have been chairman for six years. I am also involved in Family Council Network Four, on the steering committee

and as an executive member. I volunteer at Parkview—nine years, averaging approximately 30 hours per week. My mother has been a resident there for eight and a half years. My father was also a resident for one and a half years.

Parkview Nursing Centre in Hamilton is home to 126 residents, employs 140 staff members and 50 volunteers, with volunteer hours averaging 300 per month to 550 in high-activity months; for example, December.

The location is within walking distance to all amenities: shopping; banking; dentists; medical offices; schools from which Junior Buddies integrate with our residents as well as university students who train to be volunteers at Parkview; and across from Victoria Park, where residents can participate in outdoor activities. Many residents' spouses and families reside in the area and are able to walk or use public transit, while some travel with scooters.

Parkview is a four-floor structure, three floors housing 42 residents each, with 60 residents dwelling in four-bed wards. Approximately 90 to 100 line up for transportation to the main floor dining room three times a day for meals. They do not have the luxury of wheelchair-accessible washrooms. The facility was built 28 years ago according to standards of that time. The atmosphere is very homey, warm, friendly and welcoming. In fact, many residents who have temporarily come there have chosen to stay.

The purpose of my presentation: I want to ask the standing committee to amend Bill 140 to support B- and C-class homes in providing the care, dignity and respect that all residents need and should be entitled to in a safe, comfortable, home-like environment now and in the future.

**Fixed-term licensing:** The proposed fixed-term licensing scheme based on structural conditions without taking into consideration the compliance record of a facility is not realistic. Nor is the fact that such proposals are being made without offering necessary funding assistance or an attainable plan. Legislation must go hand in hand with funding to meet resident needs both in accommodations and care. How can an operator of any facility who is willing to improve structural conditions to meet the standards receive consideration and approval for additional funding under the present proposal? Fixed-term licensing as it is being presented at this time is inflicting panic and uncertainty in an already vulnerable sector of society.

**Quality accommodation:** Why aren't all three- and four-bed ward rooms to be eliminated in Ontario, just as they have been reduced or eliminated in other provinces? I believe this needs to be a priority for our government.

My mother pays the same rate as those living in A-class homes, yet she lines up three times a day to go down the elevator to a crowded main dining room. Her wheelchair doesn't fit into her bathroom, and were she in a ward room, there would be little or no privacy for her. The greater majority of residents who are capable of functioning reasonably well when entering a facility most

certainly need and should be given more privacy in washrooms, personal space and sleeping areas.

**Care:** Living in beautiful surroundings does not necessarily mean residents are receiving the amount of care they should. Many who have come to our home have made definite improvements both mentally and physically with the therapy and the attention they receive. Volunteers are a vital part of residents' daily activities and well-being, especially with the workload that is expected of staff—2.5 hours of care per resident just doesn't cover it.

Taking into consideration what other provinces have accomplished to date, there are several concerns that still leave Ontario falling below the standards other provinces have in long-term care. In fact, even within our own province, standards of care and accommodations for residents in B- and C-class homes greatly differ from others in class A and newly restructured class Ds who pay the same rate. Every resident deserves equal treatment now and in the future.

**Wheelchair-accessible washrooms:** Wheelchair-accessible washrooms would not only give residents more dignity but would also be beneficial to staff, who at present have little or no space to work in when assisting in toiletry. This would also help to cut down on staff suffering from injuries and thus help reduce absenteeism.

1310

**Changes and improvements to buildings of B- and C-class facilities:** I want the government to make it feasible to have the owners of my mother's home make structural improvements to Parkview, with plans that are approved by a qualified team of architects and builders, to make Parkview an A-class home.

**Relocating:** I have heard assurances that beds will not be lost or closed, but under Bill 140, I understand that the licence can be transferred to another area. We need Parkview in the area that it is in, not somewhere else that is inaccessible. I don't want to see spouses and families of residents separated from their loved ones, especially if transportation is an issue, thus threatening the well-being of all parties.

**The compliance program:** Structural standards and care standards need to be established for all inspectors to abide by so that the compliance program has more uniformity and stability across the province. The proposal to withdraw funding for non-compliance threatens the safety and lives of the residents involved. I cringe at the fact that my mother or other loved ones could be subjected to such an ordeal.

In closing, I would like to commend all those who have been instrumental in compiling all the information to present the Long-Term Care Homes Act. Your efforts and your perseverance in promoting a better quality of life for seniors and long-term care are appreciated. I trust that the standing committee will strongly consider the issues we have concerns with and ensure that the necessary changes are made to Bill 140 so that the aging population that has contributed so much to Ontario as veterans, voters and taxpayers will not be forgotten by our government, now and in the future.

In addition to the needs referenced in our presentation, I urge the committee to support the detailed amendments submitted by the Ontario Long Term Care Association to address the issues we have raised. Thank you.

**The Chair:** Thank you. There's just over a minute for each party. Do any of us remember whose turn it is?

**Ms. Smith:** Mine, I think.

**The Chair:** That's what I thought. Ms. Smith.

**Ms. Smith:** Thank you, Mr. Chair. I know you didn't just forget me.

Thank you for your presentation. I know I'm coming to see you on February 6; I'll be there. I'm sorry that we had to change the date, but we were doing something special the day we had scheduled.

About the licensing being transferred outside the area: Actually, the structure that exists now around licensing allows for the transfer of licences to different areas, so in fact we are putting more restrictions around that than what already exists—just to address that.

Around the number of hours, and you talked about 2.5 hours of care: In fact, the government has recently released a number that averaged 2.86 in the province.

You talked about falling below the standards of other provinces. There's no other province that has a legislated standard, and there are few that have set targets. Some have set minimums—1.9, 2.1. No one has a minimum of 3.5. It's a real mixture of who has what requirements, but there are no minimum standards of 3.5.

I just wanted to ask you what you would include in that 3.5 number or in whatever number you're proposing as far as what you would see as being calculated for care for your residents. I'll ask both of you, if we have time.

**Mr. Baglole:** Certainly I think we're talking about direct resident care. We're not talking about maybe sick hours or when people are out of the building; it's direct resident care. I would even question whether an activation staff assisting with the dining of a resident should be considered as part of the hours or not, those kinds of issues. But I think we would like to see maybe not so much a cookie-cutter approach, but a real need-based one: Does the home need 2.5 hours or do they need 3.5 hours for that particular care that they're delivering?

**The Chair:** Thank you. We're out of time. Mrs. Witmer?

**Mrs. Witmer:** Thank you very much, Kevin and Arlene, for coming forward. Mention was made of the fact that you are a home that has four-bed wards, and obviously you need money for capital redevelopment. I did put forward a private member's motion. It was supported unanimously by all parties in the Legislature, and I am optimistic that the government will follow through on that commitment, as well as providing the additional \$6,000 that they had indicated they would make available for each individual. As you've pointed out, the demands today on staff are onerous. This will only increase the burden. Unfortunately, the needs of our residents are much more complex than they were in the past. I'm optimistic and I hope that the government will do so.

You mentioned that your mother pays the same rate as somebody in an A home. We continue to hear that it is a



bit of a double standard. Some people are almost second-class citizens. They're in the new, 1998-designed homes and they're in a homelike environment, with small dining rooms, etc. I hope the government recognizes that we have to treat all of our older population fairly and equally.

**Ms. Martel:** Thank you for your presentation. I want to ask you a question about volunteers, because you said that you were. Does the home have a paid staff person who coordinates volunteer activities?

**Mrs. Fitzpatrick:** Yes, we do. We have our activity director.

**Ms. Martel:** Full-time?

**Mrs. Fitzpatrick:** Full-time.

**Ms. Martel:** Okay. The legislation says that every home shall have an organized volunteer program, and I don't have a problem with that. But then it says, "To be included in program," and it lists the range of people who need to be contacted in order to see if they'll participate as volunteers: schools; spiritual and religious centres and organizations; businesses; service clubs; ethnic, cultural and linguistic organizations; and other organizations and institutions within the community. I'm just wondering, do you think that's a bit much? Do you think that the volunteer coordinator isn't already trying to do those kinds of things?

**Mr. Baglole:** Yes, I think it's slightly onerous because then she would have to keep track of all those places that she contacted. So it's another amount of her time taken up in documenting that she contacted spiritual, schools, those kinds of things. She does that anyway. That's one of her mandates and one of my expectations, one of the owner's expectations, that she would do that, and to great fruition for over 20 years. It seems onerous that she has to do that now to comply or to prove that she's done that.

**The Chair:** Thank you very much.

#### TRILLIUM VILLA NURSING HOME FAMILY COUNCIL

**The Chair:** The next presentation is Trillium Villa Nursing Home.

Welcome. If you would state your name for Hansard.

**Ms. Brenda Marshall:** Good afternoon. My name is Brenda Marshall. I am the chairperson for the family council of Trillium Villa Nursing Home in Sarnia, Ontario. I have been a member of this council for approximately one year, yet I have been associated with this nursing home for the past 17. This home is my home away from home, and the 152 seniors who reside there are my extended family.

This long-term-care home is one out of three nursing homes in our community classified as a class C home. There are 35,000 seniors living in class C homes. There are 75,000 seniors living in long-term care across Ontario. It is not hard to do the math; almost half of our seniors live in C homes. These are homes that do not meet the new design standards, as do the A homes, yet

the residents of these homes continue to pay the same fee as a resident of a newer home.

I have come here today to ask the committee to amend Bill 140 and improve the licensing portion of this bill. We need to include provisions that provide these residents with the certainty of knowing that their home will continue to be there for them. Our community needs to be reassured that when the time comes, they too will have long-term-care access that meets the current and future needs of our baby boomer society.

There are too many unanswered questions that this bill does not address. This act specifies that a licence be issued for a transitional term of not more than 10 years for a home classified as a C home. What then? Will our home be closed or downsized? Will our loved ones be transferred to a different community, where there is no family, because there are no beds left in their own community? What happens if the home needs the roof replaced in a few years? Will the owner be able to find financing for a new roof that will last years beyond the life of the licence or will they be forced to carry out temporary repairs using duct tape until the uncertainty has been removed? Once the licence has been renewed, how much longer then? Will we meet those years' standards? These are questions that are being brought to me by residents and family members of our home. These are questions that I'm unable to answer for them, and I should be able to answer them. I am part of family council, and the families of these residents look to us for answers.

#### 1320

The government wants the licensees and families of these seniors to take more responsibility, yet you make it harder each and every day for us. Why have this bill if, in the end, there are not enough homes available for our most elderly, frail and vulnerable citizens because they have been closed? The seniors in our communities across Ontario deserve better than this.

Long-term-care homes need to stay open and the government needs to assist us with capital renewal like there was for the 20,000 new beds and the 16,000 rebuilt D beds. I am sure that we can all agree that the contents of this bill are to protect the residents in these facilities. Yes, the government is ensuring tougher inspections, prosecution for those who abuse and neglect our loved ones, ensuring that a nurse is on staff 24/7 and restricting the use of restraints, but this bill is far from being superior, and superior it should be before it is passed.

We need the government's commitment to provide more capital funding to upgrade or rebuild our older facilities. A rebuild program from this government is a must. The operator or licensee cannot do it on his or her own without financial backing. If you were a loans officer, and a client came into your office and asked you for X amount of dollars but could not ensure that the payment would be returned in full because of the uncertainty of the outlook for the business venture, what would you do? Grant the loan? I think not.

My mother-in-law is in the last few days of her life, as I speak here today. She has no privacy when family visits

because she shares her tiny room with another wonderful lady who must watch her die, knowing that one day it will be her turn. Should we ask her to leave her room because we would like some privacy? I think not. This is her home as well and she must be made to feel comfortable in it. We also need to give the residents of these facilities the comfort and dignity they so rightly deserve. There are three to four residents sharing a room as well as a washroom. Try going to the washroom in a wheelchair when you cannot get the chair through the bathroom door. These residents are living out their lives and dying without privacy and dignity, and it is incomprehensible. They call these the golden years? I'm not so sure anymore.

We have some wonderful staff at Trillium Villa and, believe me, I have watched them come and go over the years, but they can only do so much. We, as family members, can only do so much, and I must tell you that we are all burning out. Together we are caring and loving human beings and, if not for us, our loved ones would not live the fulfilling lives that they do. If you choose to close down these older homes, you and you alone are giving our seniors a death sentence. We need to work together, compromise and create a bill that will keep our long-term-care homes in existence. If anyone here has spent time in a long-term-care home like I have, parts of this bill would not be written up as such. It has taken three years to write this act, yet you want to pass it through as quickly as possible. Shame on you. Shame on all of you.

I beg you to take into consideration each and every one of the speakers who have presented their cases in the last two weeks. We are the ones who know the ins and outs of these homes. We are the ones who know what needs to be done and the help we need to accomplish the task.

I was asked by the president of resident council of our home to bring this letter that I hold and to read it to you. It is a promise that I intend to keep. I would like you to listen to their voices through mine.

"Dear members (standing committee of social policy):

"As residents of a long-term-care home in Ontario we would like to express concerns regarding Bill 140. We worry about the consequences of this bill and ask that you reconsider how it is written. We live in a home that is a C classification. Our care here is excellent considering the stressful conditions associated with this older building, and the lack of funding dollars for adequate staffing in long-term care. Both the insufficient Ministry of Health funds and the age of the building have an effect on the amount of staff time available to meet our comfort and needs. Older C buildings like ours are very challenged to meet ministry regulation/standards. After all, many of these standards were not in place when this home was built, or have changed. Residents coming into long-term care were not as disabled, dependent and in need of real care to the same degree as most residents in our home and other homes. It is frustrating to know residents in newer homes don't have to be concerned

about some of the day-to-day concerns we have in an older building. For example, hallways are too narrow for wheelchair traffic; most bathrooms are shared by four people, are too small for a wheelchair to fit through the doorway and don't allow staff to assist us safely; storage space is just not available so our hallways are cluttered; bedrooms are too small to allow free and safe movement; there is no room for a casual chair to sit in or for company; dining rooms have 60 to 80 residents (imagine the noise three meals a day)" in that room, no relaxation whatsoever; "dining rooms are too small for safe and free movement with so many using walkers and wheelchairs. These are only a few of the problems associated with an older home. All of these factors affect our care, our comfort, and the availability of staff to meet our needs. We watch as staff work twice as hard overcoming these challenges. The number of new residents we get in a year is by far more than in any A or B home because many come for such a short time and then move to a newer home. We barely get to know many of our neighbours. Again, staff time is taken from us to accommodate for this constant change in residents. We understand there is no additional ministry funding to help overcome these challenges. Something is very wrong with this picture.

"What has happened to the renewal projects initiated several years ago? The Ontario government started to replace older homes but is not committing to continue. We feel like we are in limbo. Will our home be licensed in a few years from now, or will it perhaps not be renewed? If Bill 140 passes, who is to say that homes in good standing like ours and other C and D homes will not all of a sudden be closed? How long will this home be left before upgrades or rebuilding take place? Why would the owners want to invest in long-term care without provincial support and funds? Is there any security for us as residents, for our families, families and residents of the future, the owners and the staff who work so hard? We, and the residents of the future, need reassurances that the government will continue their unfinished task and provide equal accommodations and funding support for all residents in long-term care. Policy-makers need to make policy in conjunction with those who make decisions regarding funding.

"Long-term care is already stressed. Our care needs are incredible. Our personal needs will not be met as you expect if this bill is not rewritten. It will add complications that will again take time away from direct care. We deserve better. We deserve comfort in our living arrangements and the dignity of having staff who actually have the time to meet our needs. That requires more direct care staffing hours, more funds for direct care staff, less paperwork that takes staff away, a building that meets ministry expectations and the knowledge that our home will be licensed annually if we meet standards.

"Our question to the provincial government is, who are you accountable to if you don't write this bill well? Who pays the consequences? As we see it, it will have a trickle effect down to the very people you think you are helping—us, the residents in long-term care and those of the future.



"Respectfully,

"On behalf of Trillium Villa Nursing Home Resident Council

"Al Muxlow (president)

"Mary Lindsay (vice-president)."

The residents of these homes are the heart and soul of Bill 140. If you do not want to listen to them, then what are we all doing here today?

I thank each and every one of you for the time you have given me here today, and I respect the job that you have at hand. Thank you.

1330

**The Chair:** Thank you. We have about 40 seconds per caucus.

**Mrs. Witmer:** Thank you very much for your presentation, Brenda. Over the course of the last couple of months, from when the bill was introduced to where we are today—I had grave concerns when the bill was introduced; I now have far beyond grave concerns. We've heard from people like you. I will tell you, this bill, with which probably the government intended to do good, is really going to have a dreadful impact on the people who live in the homes, the staff who work in the homes. We hear about the very stressful conditions. I think at this point in time—I had 300 amendments. I can't possibly introduce all those amendments. It's not humanly possible. I'm almost believing now that this bill needs to be rewritten. The government needs to understand that it's a bad bill. It doesn't meet the needs of the residents. As I said, it was probably well-intended, but I don't even think you can improve it at this point.

**Ms. Marshall:** Thank you.

**Ms. Martel:** Thank you for your participation here today and the work that you do on the council. Because we're so short on time, I'll just make this statement. We've heard about the licence issue again and again over the past five days. Clearly it is a huge issue both financially for a number of homes and for the—I don't want to say "security"—comfort of residents to know how this will be resolved. I'm hoping that the government is listening to the concerns that have been raised about this very particular issue and that we come to a resolution for it, because the anxiety that's out there really cannot continue, either for the staff nor the operators. Thank you for your presentation.

**Ms. Smith:** Thank you for being here and for your involvement with the family council. I note that there has been a real improvement in the home over the last four years with respect to compliance. Now they're doing a great job, so I want to commend you. I'm sure you've been involved in encouraging the staff and ensuring that that's happening, so that's just great. I also note that Trillium Villa has hired over 20 new staff since we've increased the funding. I just wondered if you could comment on what some of those new staff are doing for your residents in the Villa.

**Ms. Marshall:** If the staff has increased, I have not seen it. It is very understaffed. We need a lot more staff at that home. I know you have done a lot of research in

the past, Monique. I don't know if you've ever shadowed a staff member in a long-term-care home for a whole day—not just a visit; I'm talking about a whole day.

**Ms. Smith:** An eight-hour shift.

**Ms. Marshall:** You would understand the problems that they have during the day.

**Ms. Smith:** So you've seen no substantial difference since they've hired 23, I think, new staff in your home?

**Ms. Marshall:** I have seen differences over that time, but we're still talking shortages. There are differences, but there is still a shortage.

**The Chair:** Sorry; we're out of time. Thank you.

## GUELPH WELLINGTON HEALTH COALITION

**The Chair:** The next presentation is the Guelph Wellington Health Coalition.

If you would state your name.

**Ms. Magee McGuire:** I'm Magee McGuire. Before I begin, on behalf of the Guelph Wellington Health Coalition I would like to extend our appreciation for all of the hard work that you and your staff have obviously been putting into this new bill. But we're not out of the woods yet.

I chair the Guelph Wellington Health Coalition. We have been under the umbrella of the Ontario Health Coalition since 2002 when the Romanow report was being developed. We endorse the principles of the Canada Health Act, especially universal medicare. As advocates, we provide a forum through media and events for public discussion on health delivery and funding when it affects our own community in LHIN 3. This presentation reflects the input of our members, who have come from the community, local hospital unions, chapters of the Council of Canadians and the Registered Nurses' Association of Ontario, the district labour council, teachers' federations and the student association of the University of Guelph, to name a few. My personal contribution is supported by my current studies in health care leadership and my past 36 years of experience in the field as an RN.

Clearly, Bill 140 has a dedicated team of engineers who have created minuscule avenues of scrutiny for issues that have not been attended to before. The most important feature of your effort has been exemplified by the great changes that your committee set itself on course to follow after the Red Tape Commission recommended replacing the three existing acts that govern elder care in Ontario. You have clearly denoted the importance of provision for the continuity of care in all facilities regardless of whether they are long-term care, homes for the aged or retirement homes. You have aimed for quality and are attempting to focus on the core of it. We have discovered that some facilities offer all three levels, which gives greater opportunity for spouses who want to be close to each other and their families.

There are some distinct challenges to this act, which has the characteristics of a transformational leadership,

and I will speak to these. Clearly, this ministry has a vision for Ontario, and the mission statement for each facility needs to reflect this vision. We feel that language to guide such a mission statement is missing. We would also like you to endorse a values statement to reflect that mission.

Standards are an ominous task but not prohibitive in setting challenges. First of all, you have focused on the very important need for a care plan. What is missing is a universal statement of purpose. It must include: first, care to adequately meet the individual needs of the resident; second, a focus on safety, whether it is for a resident or caregiver or the environment; third, effectiveness that is inherent in a principled plan of assessment, planning, implementation and evaluation and revision; and fourth, efficiency. "Efficiency" is a term that requires a clear definition of its expectations. Standing alone, it does not include all these other processes, but without them it is not efficient. If it is not effective, it is not efficient.

You have highlighted the importance of quality and risk management in many different passages. However, we found that the paper was not comprehensive because there was no cross-referencing to related goals. For example, the language of section 6 on plan of care and 7 on care and services is not exclusive to other assessment language found under section 36 on regulations and admissions, section 37 on training and section 74. Simultaneously, it raises the flag on exemptions in section 139, general management in section 82, and municipal and joint homes and First Nation homes in section 116, part VIII. The relationship of these sections to each other strongly indicates the need for universal standards that meet quality assurance and risk management standards for all residential homes.

May I point out to you that a universal standard for care plans is already a construct of the nursing profession, which has created a tool for continuing improvement? It is the required standard of every registered nurse as a prerequisite skill to practise. All those under his or her supervision must provide the standard to which he or she is responsible. This is a poignant fact and a grave concern to the many RNs facing a future of nursing without support for these regulated standards.

Let me say it another way. You have already indicated that there needs to be an RN on duty 24/7 in all of these facilities. The standards of operation and clinical delivery by every service must minimally be implemented to the lowest, most common denominator of standards of the RN. In other words, they are quite high—and that is what you want, after all. If you do not do this, you will have greater recruitment and retention issues than those that already exist. It is not only the availability of an RN that is the issue; it is the issue of the standards that must not conflict with the ethics of the RN. It is about the lack of attractiveness to this profession. Nursing journals have focused on this topic for many years, especially since the cutbacks. These core standards need to be documented into the code of ethics for this act. Then it becomes everybody's responsibility.

This now brings me to the issue of leadership. You have fundamentally created a transformational standard of shared leadership, and this is golden. Therefore, it will be necessary for all the affected facilities to provide leadership that is equally transformational, and that means education and participation will become the hallmarks of excellence. All of these can be constantly monitored through continuous improvement strategies that meet community standards. Quality cannot prevail without transformation. The nurse manager must be supported to marry the operational and managerial objectives to the clinical objectives serving the needs of the residents. This is missing from the language.

#### 1340

There will be strong competition for skilled resources such as RNs. It will be the personal care worker, or PSW, who will be doing most of the work. The scope of practice is limited for the PSW, who has no regulatory body. He or she may have a short community college education or be trained on the job, but without standards, it is difficult to measure the standards of this group of dedicated workers. The responsibility for standards and safety again falls to the one RN who must be present. There is no language in the act recognizing the ongoing need of education for these workers, yet this is part of the transformational process. At some time in the near future, there needs to be a discussion on the practice and ethics of the PSW and whether this group needs to be regulated.

It is good to see the word "training" in print. The most common reported experience about education in the workplace is that when staff goes to training, there is a reduction in staff for supervision, and this is where managerial decisions can shortchange the clinical standards. Yet training is supportive of those standards and is a mark of quality. There is no funding provision in the document that relates to training, and this is important. This opportunity cannot occur without the funding. Be aware, though, that even with the funding, the resources will be so scarce that training probably will require extended hours for employees until the graduates of existing programs begin to be available.

There is no reference to conflict management in the language or the standards, yet research shows that nurse managers spend up to 20 minutes of their time each day settling conflict. Once again, the cost of training will have long-term qualitative effects, with improved time management and interpersonal relationships. Please include this goal of a universal conflict policy as a condition of workplace standards.

In the auditor's report of 2002 and 2004, there was a strong reference made to the need for prioritizing quality assurance and risk management. Once again, this speaks to the need for highly qualified nurse managers, a minimum standard of care, and sufficient staff and funding to support this initiative. We strongly recommend that you endorse this specifically in the document. The ministry supports improved funding through the minimum standards set—MDS—implementation in Ontario. There is no benchmark for all facilities to begin and complete this



process. It is important to know that this process for an existing facility is demanding and stressful and therefore needs to be managed in phases. Managers report that their staff experience high levels of stress because of the countless paperwork and theft of hands-on task time.

There is a relationship between time, workload, quality and funding. The Ontario Health Coalition is advocating for 3.5 hours of care per resident to become the standard minimum hours of care for all providers in the circle of care. This is not the optimum, but it is necessary for maintaining the clinical and management standards. Presently, there is no minimum. The need for more time has been endorsed by the Ontario Long Term Care Association since March 2006 in their "20 minutes more" campaign. Likewise, the Ontario Association of Non-Profit Homes and Services for Seniors, through the Casa Verde case, demonstrated the need for more time, and therefore more funding, for meeting the special needs of residents experiencing dementia and mental challenges.

Currently, the most common funding model is the case mix index, but it does not capture all of the actual work done by a caregiver. This is critical for a worker who cannot meet the needs of the resident because, for example, the non-availability of incontinence products reduces the standard of care. In this instance, the professional standards are now also conflicted. In the circle of care, the multidiscipline approach is the best practice for overall plan reviews. Research shows that the involvement of line staff within the management circle for clinical and structural issues raises the quality of care and satisfaction for both resident and staff. So once again, the MDS assessment tool may better reflect the variable needs.

Presently, the copayment for basic and private is universal throughout Ontario. However, the private-to-public ratio is 60-40. Many seniors have expressed concern that they fear a lack of availability of non-preferred beds because of their lower incomes. Hospitals are extending hospital stays for non-acute patients waiting for admission, but there are no non-profit beds. If you need an example of that frustration, please recall the recent example of the Kingston lawsuit caused by 60 patients in non-acute beds waiting for placement. This often contributes to a backlog in emergency departments. Therefore, we ask you to reverse this ratio to 40 preferred-60 non-preferred beds and focus on this by dedicating all new beds to the non-profit sector.

Guelph has been approved for 90 more beds, but residences which are substandard to the new building guidelines will lose out because they are not eligible. There needs to be some funding for building standard upgrade built into the long term for any of these buildings so that this kind of thing will not happen. They are expensive to build and expensive to retrofit. Storage is such a big issue that, alone, it can improve the quality for both workers and residents. It is important to plan to work together to find a solution for these homes.

This brings us to the big issue of public trust. In the community, there is a need to build trust—

**The Chair:** One minute.

**Ms. McGuire:** —that this sector will be well maintained, and inviting family representatives or legal designates into the circle of care is one good way of guiding this.

I'm going to skip down to the restraint policy, which I'm sure you've heard about, because we feel that it is extremely important that where chemical restraint is used in an acute situation, there should be an immediate consultation of an experienced doctor of gerontological pharmacology, and it may not be the best skill set of the resident physician.

Finally, in my last thought, if I leave you with anything that's really important in this presentation, I want you to remember the role of the registered nurse and the standard by which she performs, because it will be pivotal to the success of this change. I ask you to honour and protect this position as a core value in the passage of this document.

Thank you very much.

**The Chair:** We're out of time and there will not be an opportunity for questions, but thank you.

#### COUNTY OF OXFORD

**The Chair:** That brings us to the county of Oxford.

If you would state your names, please.

**Mr. Paul Holbrough:** My name is Paul Holbrough, warden for the county of Oxford. With me today is Tony Orvidas, director of social housing and—

**Mr. Tony Orvidas:** Social services.

**Mr. Holbrough:** Social services. Sorry.

Oxford county council very much appreciates the opportunity to make this submission regarding Bill 140. The county of Oxford, with a population of approximately 100,000 people, is located in southwestern Ontario and is comprised of eight municipalities, including three urban centres. It owns and operates Woodingford Lodge, comprised of three long-term-care homes totalling 228 "approved" beds. One hundred and sixty of these are located in Woodstock, while another 34 beds are in Tillsonburg, and the remaining in Ingersoll. The two 34-bed satellites are "new builds," while the 160-bed Woodingford Lodge Woodstock is currently being rebuilt, with residents being relocated to the new site later this year.

Woodingford Lodge has already struggled to achieve much of what is contemplated in Bill 140. While the county of Oxford is supportive of the principles of Bill 140 that are related to the care and safety of residents and of the province's efforts to "build a strong and safe long-term care system," the county is, however, concerned about the way in which the government proposes to apply the legislation.

This submission will focus on five matters of interest to Oxford county council. The first two deal with perceived omissions in Bill 140, while the remaining three make recommendations regarding amendments to various sections of the proposed act.

A paramount concern of the county of Oxford related to this piece of legislation deals with the failure of the province to make a commitment to ensure that there will be sufficient long-term-care beds available in Ontario in general, and in Oxford county in particular, to meet the future long-term-care needs of the residents of our communities.

Point number 1: enhanced staffing levels and associated funding. A simple answer to meeting the needs of residents in long-term care is bringing Ontario's long-term-care staffing levels up to those of other provinces like Saskatchewan and Manitoba, both of which provide more than three hours of care a day. As the Ontario Long Term Care Association has stated, "This 30-minute gap between care required and care funded is the challenge that residents, families and the" long-term-care "sector believe must be a government funding priority."

Various unions, as well as the Ontario Health Coalition, among others, have expressed similar concerns about this issue.

Increased staffing levels are particularly critical in resident home areas of long-term-care homes. These are areas that are designed and used as specialty or "secure" units for residents with cognitive impairments and where there is a significant risk of serious bodily harm to the residents or other persons.

1350

In an attempt to more appropriately meet the needs of its residents, the county of Oxford currently staffs Woodingford Lodge at an average of approximately 2.8 hours of personal and nursing care per resident per day. Staffing levels in its secure wing are naturally higher. Provincial funding does not cover the costs of the additional staffing. The county has to provide a substantial subsidy to offset the additional expenditure. Here you'll see a recommendation that we're suggesting.

Number 2: a commitment to increased operating funding. Long-term care is chronically underfunded. It is therefore critical that the province honour its commitment to provide \$6,000 per resident for the purpose of care and that it also provide new funding allocations in line with any new requirements. The county of Oxford contributes some \$5 million per year to the cost of resident care and services at Woodingford Lodge to meet the current standards. It is becoming progressively more difficult to maintain this level of subsidy due to the capital financing commitments. Unless the government provides additional funding, Woodingford Lodge will be forced to apply even more of its limited resources to meeting all the new administrative requirements of the act. As the Ontario Association of Non-Profit Homes and Services for Seniors has stated, this "means that less money will be getting to the bedsides of residents."

Establishing new requirements and standards without providing the means to achieve them is only a prescription for failure. As an example, the act identifies new training requirements for staff and, while everyone agrees that more training would be good, the act is silent on any commitment to provide funding to make this happen.

It should be further noted that in section 88 of the proposed legislation, the Minister of Health and Long-Term Care makes no commitment to providing funding for long-term-care homes. The county of Oxford fully understands that more funding is a budget issue. The fact that Bill 140 asks long-term-care homes like Woodingford Lodge to do what is not possible at current levels of funding is, however, a legislation issue.

Number 3: a requirement to establish and maintain a home. Under section 117 of Bill 140, southern municipalities will continue to be required to establish and maintain a long-term-care home or joint home or help maintain a home or joint home with the ministry's approval. Northern municipalities are exempt from this requirement, as is Pelee township. The county questions the reasoning behind this requirement for southern municipalities when the province is not prepared to provide these municipalities with sufficient resources to meet the care needs of the residents in their homes.

Furthermore, under section 133 of the act, the ministry may order renovations, additions or alterations of a municipal home and require that the order be complied with by a certain date. This would be done without any commitment from the Ministry of Health and Long-Term Care for additional funding to cover extra costs associated with the order. There's a recommendation on that item.

Number 4: duties of directors of a corporation. Section 67 of the act makes every member of the county of Oxford council potentially guilty of an offence for any infractions of administrative requirements in the bill that have no connection to the well-being of residents. This is further expressed in section 22 of the proposed legislation where, for example, misuse of funding or failure to report an incident by either an administrator or other staff member would be grounds for charging members of council.

Bill 140 makes members of the board personally liable for the failure of employees to meet the requirements of the act. The penalties even exceed those identified in the Public Hospitals Act. The county of Oxford questions why the crown, as a partner in care, appears to be exempt from any liability at all, especially when it comes to ensuring appropriate levels of funding.

Number 5: a prescriptive regulatory environment. Bill 140 takes a command-and-control approach to long-term care, which, according to the Association of Municipalities of Ontario, contrasts with the previous statements by the Premier and the Minister of Health and Long-Term Care that acknowledge municipal leadership on the issue.

If Bill 140 is passed with the current language, it will increase documentation requirements and thus staff workload. Woodingford Lodge employees will have to spend a great deal more of their time and resources on compliance and administration. The county of Oxford is therefore very worried that the proposed legislation will lead to a reduction in care and services for our residents rather than an increase.



The proposed legislation comes across as unfair and heavy-handed, particularly in section 156, with compliance and enforcement, where Woodingford Lodge could be subject to a non-compliance order whether or not the home "took all reasonable steps to prevent the non-compliance."

Without question, a long-term-care home must be held accountable. The county of Oxford supports measures that will enhance standards, and agrees that there is a need to address the small percentage of homes in the long-term-care sector that would be considered "bad apples." The county is concerned, however, that rules and regulations alone will not ensure resident care, security and safety. It also takes resources.

In conclusion, the county of Oxford would very much appreciate the committee's consideration of the five matters that have been raised in this submission. If the province continues to require municipal involvement in the long-term-care sector and is prepared to properly fund this involvement, the county will continue to play a leadership role in providing quality care for the current and future residents of its long-term-care home and to work with the government to make lasting improvements to the long-term-care system in Ontario. Unfortunately, Bill 140, as it is now drafted, does not encourage a true partnership between providers and the government and appears adversarial in nature.

The proposed legislation is a major and long-awaited development, and with the appropriate amendments it will offer a unique opportunity to foster a more positive relationship between government, care providers, residents and their families. Thank you.

**The Vice-Chair (Mr. Khalil Ramal):** Thank you very much for your presentation. We have three minutes left. We'll have one minute for each side, and we'll start with Mr. Hardeman.

**Mr. Hardeman:** Thank you very much, Warden, for your presentation. The number one issue in the whole presentation appears to be that we can make these changes, and a lot of the changes are good for the system, but what we need is funding to go with it. So we'll leave the funding as the number one priority.

As the second priority in your presentation, what would you say if we could convince the government to make a change, but only one? What would it be in the bill that would make this a better bill as it relates to long-term care and the county's operation of Woodingford Lodge?

**Mr. Holbrough:** If I could maybe turn that over to Mr. Orvidas, who, as I mentioned, is the director and has a little more day-to-day interaction with staff, the residents and also family members.

**Mr. Orvidas:** I think enhanced funding is a critical component. However, I think that's so closely tied to operational funding that one goes hand in hand with the other.

An area that we have particular concern about, as has been mentioned, is the prescriptive regulations and the need for staff to spend so much more of their time, then, to meet those requirements rather than doing what they do best, which is bedside nursing.

**The Vice-Chair:** Ms. Martel?

**Ms. Martel:** Thank you very much to both of you for your presentation and for the county's work in long-term care. I want to focus on money as well. I look at what a licensee's, or, in your case, because you have approved beds, what your responsibilities are with respect to ensuring that the care plan that's developed is totally complied with: that you are sure to have an organized program of recreational and social activities, an organized program of nutrition care, an organized program of housekeeping, an organized program of volunteers, etc. You're already putting in \$5 million over and above what the province puts in. If you don't get some support for the changes here, along with the money that the government promised in additional funding for residents, what are you going to do to make sure you can comply with everything that's set out here?

**Mr. Holbrough:** We've been fairly proactive in trying to initiate volunteers. We have a very strong volunteer base within all three of the homes. But, as everyone's aware, volunteers also become tired.

The funding: Actually, the \$5 million is probably a little conservative. We're probably closer to \$6 million a year, within our budget, which we're just going through now, and it's a concern. We did go through an operational review that did create some pain within the organization, mostly staffing cuts; that's where we've basically gone. We've cut some staffing levels—that is, decreased their level of care—and created very, very poor morale. We're trying to work through that with our association, our residents, our family councils and so on and so forth to make it a little more palatable, but it's still not very appropriate for the residents.

**The Vice-Chair:** Thank you very much. Parliamentary assistant?

1400

**Ms. Smith:** Thank you for being here. I noted at your three sites that you're doing very well on compliance, so congratulations on running some great homes.

The list that Ms. Martel just went through with you of the different programs that are required: I am quite sure that your home is already running all of those programs because they're already required for the most part, and I would be very surprised if you weren't already running a fairly healthy volunteer program.

I did want to ask you about the minimum standard, which is getting lots of attention, lots of discussion. You said that—well, I won't get into the whole debate about who is doing what across the country. Needless to say, I contend that there is no jurisdiction that has a minimum standard of 3.5. Very few have minimum standards at all. You state that your calculations show 2.8 of personal and nursing support. I just wondered what you would include in that when you do that calculation.

Then, because he's going to cut me off, I'm going to put my other question really quickly. You talked about your resident home areas or your secure units. We had another presenter this morning who talked about the lack of need for consent to move someone into that. I just

wanted to know your opinion on that, whether or not you feel there should be rights advice in that consent provision before someone is transferred into secure.

So, minimum standards and secure units.

**Mr. Holbrough:** On the minimum standards, as I say, we're at 2.8 hours per resident. I know that's been debated publicly within our local municipalities. The CAW says we include administrators and not hourly staff but administrative staff within the organization, within those 2.8. We're of the nature that we believe they aren't. That's up for public debate and you could probably play with numbers all day if you wanted to.

**The Chair:** We're short on time.

**Mr. Holbrough:** Fine. We're maintaining it at 2.8. We'd like to see it increased, but how we do that is probably not without funding. I'd ask Tony to answer the last question, if possible.

**Mr. Orvidas:** Regarding that component, personally, I hesitate to make any definitive comment on that.

**The Chair:** Thank you.

#### COUNTY OF ELGIN

**The Chair:** The next presentation is the county of Elgin.

Welcome. If you would state your name for Hansard.

**Ms. Lynn Acre:** My name is Lynn Acre. I am the warden of Elgin county. With me today are members of staff, including my CAO and the three directors of our long-term-care facilities.

First of all, we want to thank you for adjusting your timetable and holding these public consultations. Important and timely legislation such as this deserves our full attention. While we salute the desire to improve, we lament many aspects of your approach.

By way of background, Elgin county owns and operates three long-term-care facilities for a total of 247 residents. We have an annual operating budget in excess of \$15 million and we top up the ministry's contribution by more than \$3.5 million every year. For the record, we want you to know that we do support the submissions of AMO and OANHSS. The fear of administrative overburden is real; the apparent lack of specific support for the not-for-profit sector is of concern; the potential for micromanagement and somewhat punitive regulations is worrisome; the imbalance of individual rights at the expense of the collective is troubling; the problems of fixed-term licences and mandatory capital improvements are disconcerting; and the liability of directors is extremely problematic. We note that detailed explanations of these concerns are well documented in the submissions from our colleagues. We're certain that you will hear more about those concerns from others today, and we encourage you to consider and address those issues.

Our focus today is on but one of the many important and troubling aspects of the proposed legislation, that being the new training requirements envisioned in section 74. In short, all volunteers, as well as staff and anyone who provides direct services to residents, are mandated to

have received training before commencing services on a variety of comprehensive subjects such as fire prevention, resident abuse, restraints, infection control and residents' bill of rights, to name a few.

In an ideal world, with adequate funding, the goals of the act would be laudable. However, in the real world, with inadequate provincial funding—and please keep in mind that Elgin's municipal subsidy does exceed \$3 million annually—they are not realistic. Besides, we currently provide an extensive and value-added orientation program to our staff, a program that will have to be curtailed in order to meet these new requirements. Moreover, including volunteers in many of the training requirements, such as restraint policies, adds another burden, more cost and unnecessary strain on resources. No volunteer is expected to apply such policies as it is a matter for the home and its paid personnel. Indeed, the opposite will be achieved, as limited resources get moved around in an attempt to comply with the legislation. Volunteers may even decline to offer their time due to stringent training requirements, and certainly our administrators, with already limited training budgets, will make sacrifices in the established training modules, which we submit are already refined.

Prescribing a strict orientation outline and time frame will be a prescription for failure for many homes and actually work against the intent of the legislation. In addition, writing such prescriptive legislation limits flexibility and innovation, and even more concerning, it limits our future ability to adapt and anticipate changing needs, because our resources will be tapped as we attempt to finance the unnecessary regulations involved in the training section of the act.

Before I conclude, I feel compelled to comment on how contradictory this legislation really is when compared with the McGuinty government's professed desire to treat municipalities as an order of government. The much-touted memorandum of understanding between Ontario and its municipalities seems light-years away from the intent of this proposed legislation. The Minister of Municipal Affairs has stated repeatedly that municipalities should be treated with respect. This proposed legislation flies in the face of the minister's mantra.

As AMO states in its brief, we are the most accountable form of government and we heavily subsidize the provision of long-term care in this province. Our record demonstrates our commitment and maturity. Please don't undermine that record with heavy-handed legislation.

I will close by urging you to consider our comments and those of our partners. Don't try to fix something that's not broken. And, if you see needed improvements, then help to fund them in a predictable manner, at an adequate level and in the true spirit of partnership.

Thank you for this opportunity to address you today, and good luck with your deliberations.

**The Chair:** Thank you. We appreciate that. I will also add, on a personal note, being the age I am, that I appreciate the size of font that you chose for this. I can actually read it.



We have close to about two minutes and 20 seconds per caucus, and we will start with the NDP.

**Ms. Martel:** Thank you for your presentation, your participation and your contribution to long-term care.

I'm glad you focused in on this section, because there's more than one problem. First of all, "volunteers" isn't defined in the legislation, so we're not sure who they are. "All persons who provide direct services to residents": "Direct services" is not defined either. So you could say to yourself, "Does that mean clergy, does that mean dentists, dental hygienists, pharmacists, doctors on a periodic basis, once a week, twice a week, who knows?" Then there's the long list of training which all of those people, and we really don't know who they are, are supposed to have before they start. I think the killer in this one is under paragraphs 9 and 10, and 10 in particular: "Any other areas provided for in the regulations." So after the long list from 1 to 9, then you have the catch-all phrase at the end. This is excessive, and I think you've made that point as well. So this whole section either needs to be thrown out or really significantly improved to make it clear whom we're really talking about and what we need them to do.

Do you have any sense, in looking at this, of how much more of a requirement in staff time this might be for anybody trying to figure out whom you have to train under this section?

1410

**Ms. Acre:** We actually anticipated that question, so I'm going to pass it over to Melissa Lewis.

**The Chair:** If you could state your name first.

**Ms. Melissa Lewis:** My name is Melissa Lewis. I'm the director of seniors' services for Elgin Manor with the county of Elgin. At the present time, our homes actually provide a multi-home, multidisciplinary orientation day in addition to the shift-by-shift training and orientation we do with staff. That day will no longer be possible because the concept really is that every month or bi-monthly we gather new staff from all of our homes and provide them with orientation centred around health and safety; infection control, which is actually presented by public health; dealing with difficult behaviours; Ministry of Health standards and policies; resident abuse and residents' rights. That day affords us the opportunity to bring new staff together to really convey to them the culture of our organization, to tell them what it is we do and how they contribute to the greater good and what their role is in long-term care. We will no longer be able to do that orientation day, and when we look at redistributing that time of training, we actually have some numbers that show it's about \$185 per participant to do that orientation day as a group. It is twice that amount, \$370, to do that same concept but as on-the-job training, because it does require more of a one-to-one model.

Our idea here really was to look at something which on the surface appears to be a good idea. It's a good idea that our staff are adequately oriented, and it's a good idea that some things happen very quickly when they start work, and there is definitely information they need to

know right away. But our concept here today was to give you in essence what happens when something that on the surface seems like a good idea becomes applied very strictly in our environment, how limiting that is. We're concerned that it's in the legislation directly, not in regulations that would provide future flexibility so that concepts and innovations such as those we have undertaken in the county of Elgin could be accommodated in long-term care.

**The Chair:** Thank you. Parliamentary assistant?

**Ms. Smith:** Thank you for being here today. I don't necessarily agree that your innovation and training cannot coincide with this piece of legislation. I think there may be some timing issues around when people come in for their training, but you're probably covering off most of what's in this list in your training already.

I did want to address just one concern I had, and the fact that you have training modules and a plan of training is great; certainly not all homes do, and that's why we have to include such things in our legislation. You talk about a requirement that all volunteers be trained in restraints policies. In fact, just to clarify, they have to be familiar with or be trained on the policy of least restraints. You're not required to teach all your volunteers about all the requirements in the act about restraints, only that your home has a least-restraints policy and what that policy is, which is the requirement in the act that you develop that policy. I just wanted to clarify that for you.

I also note that at Bobier Villa you have a kind of unique campus or setting with not-for-profit housing as well as child care. I just wondered if you could speak to the benefit to the community of that home, because it is such a unique structure and we haven't heard from anyone who has a similar model. If you could just speak to that, it would be great.

**Ms. Acre:** I'll let our director for Bobier Villa speak.

**Ms. Pat Vandevenne:** My name is Pat Vandevenne. I'm the director at Bobier Villa in Dutton. Monique, I'm very happy that you asked me that question. Bobier Villa is a very unique home. We have 57 beds and we actually have a triangle, per se, of the supportive housing next door to us, Caledonia Gardens, plus our long-term-care facility of 57. Then we have a day centre across from us. So we really have a lot of intergenerational activities going on. We have a lot of families that perhaps live in the apartments next to us and actually do not have to go outside; they can come through the enclosed walkway into Bobier Villa to visit family members. So there are wonderful linkages between those three.

**Ms. Smith:** That's so important. Thank you so much.

**The Chair:** Mr. Hardeman?

**Mr. Hardeman:** Thank you very much, Madam Warden, for the presentation. I gather, I guess from page 2, shall we say that all is not well in the relationship between the municipalities and this piece of legislation as it relates to the municipality of Elgin county. I read on the page describing the legislation the words "fear," "concern," "worrisome," "troubling," "disconcerting" and "problematic," and they would kind of say that

maybe you would like it changed somewhat before the government passes it.

We've had, I think, three presentations this afternoon from municipal homes for the aged, which of course would be yours as well. It used to be separate legislation, apart from the long-term care. The fact that the municipal homes for the aged are presently spending a great number of tax dollars to make up the difference between the cost of operation and the amount that the province provides—and then as we go to page 6, you talk about the council being unconcerned about the fact that they don't seem to be getting any recognition or respect for their input into the system, recognizing that the county of Elgin's taxpayers are putting in \$3.5 million at the present time to give care beyond the level of care that is mandated by the province. And yet here we have, in other areas, with no consultation directly to municipalities about how it should be done, the province telling them how they have to do it. I wonder if you could explain to me very quickly council's position on that: their not talking to them on the memorandum of understanding with municipalities as they were supposed to do.

**Ms. Acre:** Yes. As the county of Elgin, with the municipalities, we are the most accountable form of government. As the memorandum of understanding said, we should be afforded some respect and we should be allowed to be innovative and look for ways to change and meet the needs of our residents. When you have seemingly heavy-handed legislation like this, instead of enhancing the care of our residents, which is our main concern, it seems to be tying our hands and tying up our resources and not allowing us to do the good job that we've been doing in the past.

**The Chair:** Thank you. We're out of time.

#### LONDON HEALTH COALITION

**The Chair:** The next presentation is the London Health Coalition.

Welcome.

**Mr. Jim Kennedy:** Thank you. Good afternoon. My name is Jim Kennedy. I am the co-chair of the London Health Coalition. I'd just like to thank the Chair for the opportunity to speak today to the standing committee.

As everybody is aware, the London Health Coalition is under the umbrella of the Ontario Health Coalition. We are a network of over 400 grassroots community organizations representing virtually all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively involved and engaged in the making of public policy on matters related to health care and healthy communities. We are an extremely collaborative organization working with many different organizations. We share resources and information. We are committed to maintaining and enhancing our publicly funded and publicly administered health care system. We work to honour the principles of the Canada Health Act. We work in partnership with the Canadian Health Coalition and we obviously do coordination of community-based health coalitions.

Some of the impacts of the new act are as follows. There are approximately 75,282 long-term-care beds in Ontario. In these homes live thousands of vulnerable and dependent adults. Thousands of volunteers help out, and additional thousands of Ontarians work in assisting with daily life for the people who have been our mothers, fathers, aunts, uncles, brothers and sisters. We need to start putting our energy back into some family commitments that most of us made when we were born.

The new act respecting conditions and standards for these homes will impact millions of Ontarians in intimate and life-altering ways: the amount a time a staff person has to bathe a resident and feed residents; the quality of food that they receive; whether a resident has activities, stimulation and supportive surroundings; safety from violence for all involved in the home; illness and injury; the ability to access timely medical help; the gentleness of care that they receive; and whether the residents thrive or deteriorate. It's all going to be impacted by this bill. These issues are of critical importance to all residents, their families and their caregivers, paid and unpaid. I do feel and believe strongly that these issues are of critical importance to Ontario's policy-makers.

The key issues that we have are as follows. Through our extensive consultation with member groups, residents, family members, volunteers, care workers and facility operators, one common theme has emerged: The care levels in the facilities are inadequate to protect from harm and to ensure the provisions of a decent and dignified quality of life. Everywhere in Ontario we have heard from frustrated caregivers, residents and family members who cannot give the care they want to give or access the care they need. Families are forced to hire in extra help if they can afford it. If they can't, residents go without. Everywhere people are identifying that heavier-care residents now live in these homes. Staff feel unequipped to appropriately care for the residents with cognitive difficulties and behavioural problems. Yet, the downloading of heavier-care patients from mental health facilities and acute care hospitals continues.

#### 1420

These findings aren't localized. While good facility management and lots of volunteers can help us compensate to some extent for the inadequacies, they can't provide the levels of care across the province that are a minimum requirement to protect from harm. The evidence is that the lack of care is so widespread as to be a systemic problem that requires a change in public policy to be adequately addressed.

The evidence is that the heavier-care needs will continue, and it's going to deepen in coming years. It is now generally accepted that 60% to 80% of all facility residents have some form of cognitive impairment. In 2005, some 140,000 Ontarians had Alzheimer's disease or related dementia. This number is expected to double to 307,000 in the next 25 years. That is coming from the Alzheimer Society of Ontario's position paper on the Casa Verde recommendations of 2005.

This new legislation must ensure that the care needs of our residents are soundly measured and reported, that a



minimum care standard weighted to these assessed needs be established, that the government must fund to a level that is adequate to provide care to the assessed levels and standards, and that the facilities be held to account for providing the care for which they are funded. In its current form, the proposed legislation does not accomplish these things. We've made some recommendations to ensure that these minimal requirements be met.

We suggest some improvements in the proposed legislation as it stands. Many of the provisions of the proposed legislation reflect existing provisions and regulations under the former acts, relying heavily on the Nursing Homes Act. We support several of the new initiatives, including:

- the increased ability of residents to promote their rights contained in the bill of rights;

- written sign-off of facility operators to confirm their review of admission documents;

- the proposed intent to limit casual and agency staff to be included in the regulations is a good first step, but the limitations must be strengthened;

- the inclusion of an RN on-site 24 hours a day, seven days a week—absolutely wonderful;

- increased powers of inspectors and continuation of regular unannounced inspections. Great. It would be nice, though, to see some sort of language in that bill to have inspectors talk to family councils and patients. Far too often, those inspectors are coming into long-term-care facilities, and the only person who gets their ear is the administration. Unfortunately, time and time again there's a different story coming from the front-line health care worker that comes from the administration.

There's some prevention of harm that we have to look out for. The Minister of Health has promised a revolution to ensure that we will never allow the repeat of such preventable tragedies as the sad and painful death of Natalie Babineau from a bed sore, the deaths of Ezzeldin Elroubi and Pedro Lopez, who were beaten by a cognitively impaired resident at Casa Verde, and the many other attacks and inadequate care that have irreversibly damaged peoples' lives. But if the new act is to succeed in this, it must provide the legislation and regulatory standards that will protect residents, staff, families and visitors from harm. The coroner's jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.

These aren't localized issues. I can see today that we have some family members here in this city, such as an 84-year-old woman who went into a long-term home. She had raised her family at home, had a wonderful life, never once having to worry about harm. She was attacked by a cognitively impaired patient, the reason being that there weren't enough staff to stop that. That's appalling. At 84 years old, this woman never once has had to worry about abuse in her home and now, today, she does. We've got to stop that.

The bill must be amended so that the zero-tolerance and reporting policies conform to a minimum standard

across the province, with allowance for additions to fit the context of the particular home.

Neglect should be defined so that facility operators and the government, who bear the majority of the responsibility for funding and assessment and for spending decisions which are critical to preventing neglect, are held accountable for these decisions.

Staff who whistle-blow can still lose their jobs and will have to grieve or go to the labour board to get them back. There are cases in Ontario of firings due to whistle-blowing. This is a significant financial barrier to whistle-blowing. At a minimum, this section should be amended to ensure that financial barriers to whistle-blowing are removed. We have to make it easy for staff to come forward and report neglect. We have to make it easy for them to be able to do the right thing. People don't come forward because it's going to cost them their job. People don't come forward because it's going to cost them out-of-pocket money to try to win that job back. That's a disgrace.

There should be a proactive duty of operators to provide a living and working environment that's respectful and free of fear. The bill should be amended so that gag orders and other such clauses in employment contracts would be unlawful, and this has got to be enforceable.

Proactive public and mandatory staff education similar to the models used to prevent workplace harassment, discrimination and family abuse should be instituted. Time and time again we're having off-loading of mental patients into our long-term-care facilities. Unfortunately, our staff are not being trained properly to take care of them. We need to have some language in the legislation that affords for training.

In addition to protections for the residents, the act must also ensure that facilities are safe for staff, who have alarmingly high rates of illness, accident and injury.

The act needs to include clear assurances of staff coverage for care during absences for training. All too often, when we do get some training dollars put toward the staff, what happens is they take the staff who are on duty that day to do the training; the residents go without.

We have received many complaints about inadequate training for staff working with people moved from mental health facilities into long-term-care homes. Special training to address the care needs and safety concerns regarding residents with psycho-geriatric issues must be included in the act.

We're asking for a minimum care standard. We're insisting that the key component is the reinstitution of a minimum care standard. We recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per resident. This is to reach the goal of prevention of risk; it's not an optimum. Increases in staffing should be shared proportionately among all members of the health care team. The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have

been assessed as potentially aggressive and staff them with sufficient numbers of appropriately trained workers.

The bill should be amended to require cabinet to set a minimum staffing standard in the regulations. The regulations should require the 3.5-hour minimum care standard described above. The staffing standard should be required to meet the assessed needs of the residents. Government must provide funds in the nursing and personal care envelopes to meet the required staffing standard.

What is a minimum care standard? This is a defined number of hours of care that is attached to a particular level of assessed need. We are proposing that Ontario adopt a 3.5 minimum care standard for hands-on care. This means that a facility with an average case mix, or an average level of need, would receive resources for nursing and personal care specifically to provide 3.5 hours. Those facilities with lower acuity levels would receive less; those with higher acuity levels would receive more. We need some sort of standardized tool to determine the acuity levels across the province so that we can keep that minimum staffing level the same from home to home to home.

In 1996, as you all know, the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. We're insisting that the government reinstate a care standard to improve the quality of life in long-term-care homes. Since the level of acuity has increased with the downloading of heavier-care patients from hospitals and mental health facilities, and with the aging of residents, the standard must be modernized to meet today's care needs. Based on our research of standards in other jurisdictions across Canada and the US, we believe that 3.5 hours of care—

**The Chair:** One minute left.

**Mr. Kennedy:** —would be the minimum. This should be adopted as an interim measure while the government undertakes the research necessary to define the care levels associated with the assessed needs.

1430

How do we propose that this standard work? The government uses an assessment tool now to figure out how much care residents need. The current tool is recognized as flawed. The government is piloting a new assessment tool in 70 long-term-care homes. The tool allows facilities and the government to determine the case mix. The average case mix across the province is then calculated. Those with lighter needs than the average are deemed to have lower acuity; those with heavier needs, higher acuity. The funding that the homes receive for personal support care, feeding and bathing—and most people think that twice a week is not enough—and activities of daily life is based on the level of acuity in the home.

However, there is no expected amount of care that is attached to the average level of acuity. Many reports and exposés, and testimony from families and staff—

**The Chair:** I'm sorry.

**Mr. Kennedy:** Thank you, Chair.

**Mr. Khalil Ramal (London-Fanshawe):** We have it.

**Mr. Kennedy:** You have it, and I hope you do take the time to read it.

**The Chair:** We certainly will. Thank you.

#### CAROLYN BEST

**The Chair:** The next presenter is Carolyn Best.

Welcome. If you would state your name for Hansard, and you have 15 minutes.

**Ms. Carolyn Best:** My name is Carolyn Best. I really want to thank you for listening to my concerns today. Forgive me; I'm a bit nervous.

Background: My grandmother lived in long-term care for 13 years. Presently, my mother is in the same facility, and she has been in that facility for the last six and a half years. On average, I visit that home three times a week, three and a half to four hours at a time. The last two years, my mother has had four injuries. I now spend, on average, four times a week at the nursing home. My concerns really are on a personal level, but they affect a lot of people. My mother, because of this injury now, cannot walk on her own. There is not enough staff on the floor for the patients who have dementia or Alzheimer's. They require extra care. When I did find her injury, as I did the previous injuries, I found them myself. The staff did not call me about the injuries. I found the injuries. When I asked to take her to hospital and asked for a requisition for an X-ray, I had to beg for a requisition. I was then told to either transport her myself or pay for an ambulance. I did transport her myself and one injury required four visits. It also required a follow-up CT scan, as it was a major injury.

My next point is, I find there are too many double shifts on the floor. The staff are working double shifts because there is not enough staff if someone is sick, if someone has called in. When they work that double shift, I feel they're too tired. Maybe there could be a pool of people available near retirement or something who could be called in for a short shift or to fill in instead of using that person for a double shift. They are too tired, and they are not attentive when they're tired.

If a resident is in a home and has had an injury, as my mother did—she walked up to four or five hours a day before the injury. After the injury, she cannot walk on her own; she has to have help. Now the staff say, "We're too short. We can't walk your mother." So she sits in a chair all day. She's withering away; she's 84 years old. She was very active up to that point of injury. Even if they'd just walk her 15 minutes a day I'd be happy, but a resident should be entitled to a walk somehow. The staff said there is not enough staff to do it.

Family, I feel, should be allowed to feed their loved one in the regular dining room, whereas at the home we have to take her to a separate room and feed her by herself if we want to feed her. They say it's too disruptive, but it's also disruptive to put her in a small room and feed her by herself, because she knows that's



not her daily eating habits. So I don't agree with that. A person should be in their regular environment, because with dementia it really throws you off.

They did hire a recreation person on that floor for safety reasons when I requested it. That person was hired for four hours, supposedly from five till nine. Now that person is down to one hour a day. She goes to one floor for one hour and then she leaves that floor and goes to another floor for one hour. Most times she's doing work that the staff should be doing, not recreation with the patients. She's taking the patients into meals, which is not what she was there for. She was there for some sort of recreation.

My last point is that staff shouldn't be allowed, when there is an outbreak on the floor, to go and work on another floor and then come back to the floor they were working on. We just had Norwalk, or a similar outbreak. Staff would be working, another floor would be short, they'd be sent to that floor, and then they'd turn around and come back to the floor that didn't have an outbreak. And they wonder why the outbreak has spread in the unit. It's just not common sense. If they would use a pool and call somebody in who didn't work that day, there wouldn't be this transmission among floors. They say that the rule is they don't do it, but I'm there four days a week, and they do do it. I've seen it. When I go looking for a nurse, it takes me 10 minutes to find one, maybe 15, and then I'm told they're on another floor.

Those are my points. Thank you very much.

**The Chair:** Thank you. There is a little over two and a half minutes for each caucus, and we will start with the parliamentary assistant.

**Ms. Smith:** Thank you so much for coming and sharing your story with us today and giving us your perspective. Do you have a family council at your home?

**Ms. Best:** Yes. I have been to the family council. I've brought up my concerns at family council, and I noticed when the minutes came out at the meeting that there wasn't one item that I brought up in the recommendation, in the letter that came out. They told me that I speak too much on a personal level.

**Ms. Smith:** The council told you that?

**Ms. Best:** Yes.

**Ms. Smith:** I appreciated your comments about wanting an activity person on the floor. I would just note that in our legislation we're requiring not only that they have recreational and social activities for the residents, but, without restricting that general provision, we've also required that they include services for residents with cognitive impairment and residents who are unable to leave their room, because we know that it's very important for everyone to have some kind of stimulation and activity in their day.

**Ms. Best:** That person was hired, and when I told them about safety—there is a pod where the residents are; there is a pod this way and a pod that way and a floor in between. If there are two workers on that pod bathing a patient and there are two down there and the RN is on the telephone, you have 36 to 38 patients wandering

around hurting each other. One grabs your hand and yanks your fingers out of socket; the other one's kicking you under the knee, which happened to my mother. She had two fractures from someone just sitting and kicking. No one can see anything, because they're busy. There is nobody on the floor. They took my recommendation and they used it as a rec person, but like I said, now they've taken it away. They've got one person where they had two. The one person is one hour and one hour where they were four and four, and now they're taking people in to meals. They're not a rec person; now they're working. They're not getting paid or anything, and the rec part is gone.

We do have quite a bit of recreation in the facility. I'm not complaining about that. If we can take my mom to recreation, I take her. But with the injuries, she seems to be spending all her time in her room anymore. She can't get walked because there is not enough staff, so I go. When I ask to feed her in the dining room, they say, "No, that creates too many people in the dining room. Go to her room and feed her." When I take her to the room, she falls asleep. It's her sleeping area. It's disruptive to do that. She's used to eating with the people at her table.

So it doesn't matter what I try. I keep trying things, and I keep trying to keep out of the way. I know I'm in the way, but you know what? If you're not in the way, you don't get heard.

**Ms. Smith:** I appreciate that. I really appreciate you coming today to share with us. Thank you.

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**The Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for sharing your mother's situation with us. As I've listened to the presentations, it sometimes makes you fearful of getting older. We've heard from—

**Ms. Best:** Actually, that's why I came, because I'm probably next, right?

**Mrs. Witmer:** That's right. We've heard from concerned children, and we've certainly heard from staff who feel terribly overworked and very stressed in the environment, who have told us they don't feel they can provide the level of personal care that residents such as your mother deserve.

Were you aware of the fact that the government, when they were elected, did promise \$6,000 of additional care for residents such as your mother, but up until now they've only provided \$2,000? So if that additional \$4,000 were going to flow, people like your mother would at least have that opportunity, but so far that promise has not been delivered on. I didn't know if you were aware of that or not.

**Ms. Best:** No. You know, we just need a bit more staff on the floors that need it. There are floors that don't need it, and I understand, but they need looking after properly too. But there are floors, like a dementia and Alzheimer's floor, where if you spend time on that floor and you see what happens, it's a nightmare. And it's really hard, unless you're in the environment—people who do the funding need to spend a day or two days, a week, un-

announced; just go and be in the environment. I feel sorry for the people. They've lived a good, honest life, and they need proper care. I'm not saying the staff is not competent and they're not doing their best.

**Mrs. Witmer:** There's just not enough of them.

**Ms. Best:** There's not enough.

**Mrs. Witmer:** And that \$4,000 extra for your mother and others would allow for more staff and it would allow for them to get a greater amount of personal, hands-on care. Maybe then your mother could be walked and there would be recreational and social activities.

**Ms. Best:** When I go on that floor, I try to help other patients if I see a problem too. But then you're kind of told, "Mind your own thing," and I try to do that too. But you'd like to help everybody.

**Mrs. Witmer:** Well, it's a good thing that you're there. So many people don't have a daughter or a son or somebody there to help them, simply because they move—

**Ms. Best:** Hardly anybody goes on the floor.

**Mrs. Witmer:** That's right.

**The Chair:** Thank you. Ms. Martel?

**Ms. Martel:** Thank you for making the presentation that you did today, which comes right from the heart.

**Ms. Best:** I'm upset about the situation.

**Ms. Martel:** It was important for us to hear. My grandmother spent the last five years of her life in a home for the aged. She had dementia. She had also had a stroke, so she was in a wheelchair. She was lucky, if I can use that term, that she was in a home for the aged, because of course the municipality was topping up, so there was actually more staff than there might have been otherwise. Still, there wasn't enough.

I think that what you've displayed for us today is very clearly the need for more staff. I'm distressed to hear of staff moving from one floor to the other. I would have thought that after the SARS crisis, if we learned anything, we would have learned not to have that happen. So it really is incumbent, as the government puts through this legislation, that the government also keep the promises that it made, both with respect to the funding that Mrs. Witmer talked about and also with respect to having a minimum staffing standard. Those two things have to come, and they have to come soon.

Thank you very much for your presentation today.

**Ms. Best:** Thank you for listening.

**The Chair:** Thank you very much.

#### COUNTY OF MIDDLESEX

**The Chair:** The next presentation is the corporation of the county of Middlesex. For those who have just joined us, there are refreshments available at the front.

Would you please state your name for Hansard?

**Mr. Bill Rayburn:** Bill Rayburn, chief administrative officer, county of Middlesex.

Thank you, Chair, and members of the standing committee on social policy. We represent the corporation of the county of Middlesex, which owns and operates

Strathmere Lodge in the municipality of Strathroy-Caradoc. My name is Bill Rayburn. I am the chief administrative officer for the county of Middlesex. With me today, on my left, is Larry Hills, the administrator of Strathmere Lodge, and on my right is Warden Wes Hodgson. We appreciate the opportunity to be here this afternoon and offer our comments on this important legislation.

For over 100 years, Strathmere Lodge has proudly offered its services to the residents of Middlesex county and area. Strathmere Lodge is a not-for-profit long-term-care home, municipally owned and subsidized by the county of Middlesex. County ratepayers currently contribute close to \$1 million towards the operation of our 160-bed facility, which, as my warden reminded me today, is only the operating side. We also have a capital side to the bill as well.

I want to start my presentation today by talking about this contribution; specifically, the contribution that all municipalities in Ontario make to the provision of long-term-care services.

As you may know, approximately 30% of municipal budgets go towards supporting provincial health and social service programs. This equates to a contribution of approximately \$315 per capita that municipalities in Ontario contribute to health and social services. For comparison, in 2004, the municipalities in the rest of Canada spent \$33 per capita on health and social service programs. I don't need to tell you what a difference this means to the municipal tax rate when compared to other non-Ontario municipalities, as Ontario has the highest property taxes in Canada, and much higher than in the USA.

I tell you these facts to clearly point out that the province of Ontario is not keeping pace with their financial support of long-term care, and municipalities are carrying that expensive burden. The end result is a lack of competitiveness for Ontario's municipalities both nationally and globally. I also point out these facts in regard to Ontario's contribution to social spending to suggest to you that it is time to fulfill the government of Ontario's campaign promise to provide additional funding for long-term care in Ontario. This funding is long overdue.

Ontario's municipal governments go far beyond what they are required to do in law by investing a net \$270 million a year of municipal resources in the provincial long-term-care system through the funding and operation of homes for the aged. Why do municipalities contribute so much to long-term care? Because they recognize the need for services in their communities and because provincial funding for the provincial long-term-care system is woefully inadequate.

The other reason that municipalities fund long-term care is that we do not have a choice. Provincial legislation requires counties in Ontario to own and operate a long-term-care facility. Recently, the county of Middlesex reviewed its subsidy to the provision of long-term care and the requirement to be in the long-term-care business, and we drew some interesting conclusions.



Throughout the long-term-care bed allocation process, we heard from several private sector providers in our community. They stated that they were more than willing to build additional private facilities if additional provincially allocated beds were made available. Unfortunately, as a result of the provincial requirement for counties to be in the long-term-care business, we were left with no choice but to spend public sector dollars to compete with proposed private facilities. Considering the demand for scarce municipal tax dollars, it certainly does not make any sense to my council to utilize our tax dollars for the provision of a service that the private sector is more than willing to provide in our community.

As a result, my council is on record on several occasions for their request to provide counties in Ontario with the option of not providing a long-term-care facility if the provincial allocation of long-term-care beds can be provided by the private sector. While we recognize that this option will not be utilized throughout Ontario, there are municipalities in Ontario that would utilize this option to permit private sector opportunity and to reduce the municipal contribution to long-term care. We respectfully request that you give strong consideration to the provision of this qualified option to municipalities.

In addition to our concerns with funding for long-term care, we want to draw your attention to a specific concern with the administrative sections of Bill 140. The administrator for Strathmere Lodge, Mr. Larry Hills, will present this section of our presentation.

**Mr. Larry Hills:** Thank you. I want to address the issue surrounding secure units.

Not every long-term-care home is able to provide a secure area for those residents with dementia who need added safety and security. Since 1962, Strathmere has maintained a secure unit for the care of residents with Alzheimer disease and other dementias. Based on this experience, we are concerned that measures in this bill do not appropriately address the unique nature of secure units in homes or serve the best interests of the residents who benefit from them.

Section 28 of the bill considers residents in a secure unit as being subject to restraint. This fails to recognize the role of secure units as one of providing safety rather than imposing restraint. An environment that fosters residents' safety by reducing risk of harm to themselves and others while providing programs suited to their unique needs is not one that meets the definition of a restraint.

Furthermore, adhering to the extensive monitoring and reporting requirements that apply to restraining measures will impose a significant workload which present staffing resources do not allow. We estimate that for the 32 residents now cared for in our secure home area at Strathmere Lodge, this will require an additional two hours of nursing staff time daily, without adding to resident care or their quality of life.

The bill also places constraints on the admission process and internal transfer of residents to a secure unit. These have the potential to deny an applicant or an

existing resident appropriate care and programs. The bill proposes that a substitute decision-maker be required to give consent to placement in a secure setting. If such consent were to be denied, residents with aggressive behaviours or at risk of wandering could well be admitted into the general population of homes, where they would present a significant risk to themselves and others. For those residents already in the home and who now present a risk, the need to act is often immediate. Staffing limitations and the lack of support from outside agencies only add to the urgency often faced by homes. Confronted with urgent situations and without any means of discharge at its disposal, the home could face increased liability exposure from an inappropriate placement while lacking the ability to act responsibly to safeguard all its residents.

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The plan of care which is prepared for each resident is based on assessed needs and includes input from family. The admission and transfer of an applicant or resident into a secure unit should respect this process. Therefore, we believe that a physician's order, made in collaboration with the care team, should be sufficient to allow admission or transfer to a secure unit. The overly prescriptive measures now contained in the bill will serve to hinder access to care for those with dementia, as well as place an unnecessary administrative burden on the very staff who are charged with providing hands-on care. Our recommendation is that the definition of a secured unit be amended so as to remove it from the restraint provisions.

A word now on the liability provisions: Bill 140 creates unprecedented liability for municipal councillors, municipal governments and property taxpayers through its heavy-handed approach to the issue of duty of care. Section 67 sets out a requirement that a committee of management for a municipal home will "take all reasonable care to ensure" that the operation of the home complies with "all requirements under this act." Every person who fails to do so would be "guilty of an offence." This means, without any exaggeration, that a municipal councillor is guilty of an offence if they cannot demonstrate "reasonable care" to ensure that the administration of the home meets even the most minuscule administrative requirement.

This section is not about safeguarding the rights or interests of residents in the home, but sets out to establish liability for municipal councillors with a penalty of fines up to \$25,000 or imprisonment of up to 12 months for a first offence. Furthermore, this section would make anyone think twice about operating a home or running for a seat on council.

Interestingly, the penalties far exceed the offence provisions for members of hospital boards under the Public Hospitals Act. We urge the province to take a more reasonable approach and align the offence provision under Bill 140 with the Public Hospitals Act.

In conclusion, on behalf of the county of Middlesex, I thank you for the opportunity to present these concerns to committee. We look forward to seeing our concerns

addressed in further iterations of Bill 140. In particular, we ask that you pay close attention to the detailed recommendations being provided to the committee by OANHSS and AMO during this consultation process. Thank you.

**The Chair:** Thank you. We have just over one minute per caucus for questions. I will start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. We've heard from a lot of the municipal homes, and we appreciate the taxpayer funding that goes to support them.

You had an extensive presentation on secure units. I think you indicated here that in order to abide by the new monitoring and reporting requirements, for 32 residents it will require two additional hours of nursing staff daily. Is that right?

**Mr. Hills:** That is correct.

**Mrs. Witmer:** And that's for all 32?

**Mr. Hills:** Yes, 32.

**Mrs. Witmer:** Also, you had real concerns about the admission process and transfer based on the fact that sometimes, in order to protect the individual or those around them, there is a need for immediate action. What change would you propose the government make to allow for that type of transfer, where you wouldn't be in a position where you could face some increased liability? What should happen there?

**Mr. Hills:** In terms of admission to the home, the substitute decision-maker is proposed to be part of the process. If that is taken care of before the paperwork and the resident are at the door of our home, that's fine. But my concern is that during the admission process, if the substitute decision-maker chooses not to, and in some fashion or other the resident or the applicant finds their way through the system, we could find ourselves with a resident who requires certain care, such as a secure unit, because of the lack of the approval from the substitute decision-maker, in our general population.

So how do you fix that? I'm not saying that we want to remove the substitute decision-maker totally from the process, but I think measures need to be enshrined in the bill to delineate certain types of applications, so at the earliest stage, through the CCACs, it is identified that this person does require the benefit of a secure unit, so that in no way will they find their way into the general population.

**Ms. Martel:** Thank you for your presentation here today and for the contribution that you're making financially and in other ways to long-term care.

I want to focus on the secure units as well. When you say you've done the addition and it will require an additional two hours of nursing staff time daily to meet the requirements, can I ask how many staff you have working in that unit right now on one shift?

**Mr. Hills:** On our day shift, we would probably have five.

**Ms. Martel:** And at night?

**Mr. Hills:** We would have two.

**Ms. Martel:** So to comply both during the day and, more specifically, at night—because behaviours would be quite different—this means a significant shift away from hands-on care to the folks in that unit, doesn't it?

**Mr. Hills:** Yes.

**Ms. Martel:** And I suspect you're not in a position to hire more staff in that unit to meet those requirements.

**Mr. Hills:** Certainly not.

**Ms. Martel:** So if this section and many others are going to work at all, what is really required is that the government fund the provisions or any of the new requirements that they are making through the bill. Is that correct?

**Mr. Hills:** I would agree.

**Ms. Martel:** I think you're right.

**Ms. Smith:** Just so I'm clear on the secure unit question, can I take it that you don't believe we should require the consent of the resident or his substitute decision-maker for him to be placed in a secure unit?

**Mr. Hills:** I'm not saying that we shouldn't have the substitute decision-maker. I'm just saying that in terms of admissions, there should be a clear delineation through the admission process whether a resident is to be headed toward a secure unit or not, so there will be a separate channel of processing these applications, so homes will not find themselves with a resident who should have been in a secure unit but, because of the lack of consent provided, is now in the general population.

**Ms. Smith:** I think if you look at section 41, on the placement and the assessments that are required prior to placement, we are now going to require that the full assessment of the applicant's current behaviour and behaviour during the previous year be reviewed so that we can assure that we are doing a proper placement. As well, we require that assessments be done within three months of admission to a home. I would assume, because it's the case in so many other areas, that you probably do have a waiting list. So you probably have a bit of time, prior to admission, for someone to be assessed and therefore being able to get the proper rights advice prior to being admitted into a secure unit.

**Mr. Hills:** So long as they're channelled through the normal application process, that might be acceptable. But if there is going to be something that would be akin to a crisis admission, that's when I can see some issues arising.

**Ms. Smith:** The legislation allows for the application of the Health Care Consent Act, so for a crisis admission, the rights advice could come subsequent to that.

**The Chair:** We're out of time. Thank you very much.

## ST. JOSEPH'S HEALTHCARE SYSTEM

**The Chair:** The next presentation is by St. Joseph's Healthcare System, Hamilton.

Please state your name for Hansard. Please feel free to start.

**Mr. Bob Taylor:** Good afternoon. My name is Bob Taylor. I am here on behalf of the St. Joseph's Healthcare



System. I am a member of the community advisory committee of St. Joseph's Brantford. Joining me is Jan Lord, chair of St. Joseph's Guelph, and Marianne Walker, president of our Guelph facility. Jan and I represent many volunteer governors who serve our residents in the tradition of the Sisters of St. Joseph of Hamilton.

Our submission represents the response of our board of directors to the proposed Bill 140. While we support the bill's desired outcomes, which focus on safe, quality and respectful resident care, in its current form it will disenfranchise the contribution of voluntary governance, take away valuable resources from the residents' bed-sides and negatively impact resident and staff safety in the workplace.

St. Joseph's Healthcare System has a long-standing partnership with the Ministry of Health to provide care across a health continuum. We are responsible for the management and governance of three non-profit, long-term-care facilities: St. Joseph's Lifecare Centre, Brantford; St. Joseph's Villa, Dundas; and St. Joseph's Health Centre, Guelph.

I will now ask Jan Lord to highlight our response to the legislation, and we welcome your comments.

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**Ms. Jan Lord:** Good afternoon. My name is Jan Lord. Thank you for this opportunity and allowing us to present today.

The St. Joseph's Healthcare System recognizes that the government, through Bill 140, has attempted to develop legislation that will strengthen accountability and resident-focused care. However, one of our concerns is that the legislation leaves a really negative impression and concern about the care that is provided. Our communities are left with the feeling that the care in long-term-care homes is substandard and that accountability is not important to us. I want to assure you that, in the over 145-year history of providing health care services to seniors, the St. Joseph's Healthcare System has always taken accountability seriously, and the focus on providing quality services has been very important to us. I'm just going to highlight three major themes of concern.

The first theme is, as you've heard previously, the direct impact on resident care. While increased provider accountability is appropriate, the Ministry of Health and Long-Term Care has got to acknowledge that there is a cost attached to this and that the legislation, as written, will take critical resources away from direct resident care. Nurses may be forced to spend their time away from residents, and our sector is already stretched with the challenges of meeting their needs. Certainly, in our Guelph facility, we already supplement our direct care by a large number of dollars in order to provide a high standard of care.

Our recommendation is that the Ministry of Health and Long-Term Care honour its commitment to provide increased long-term-care funding in the amount of \$6,000 per resident per year. The other important thing is that the ministry analyze the cost for implementing the new requirements contained in the bill prior to the

implementation of the non-direct care activities, as required.

Again, as you've heard before: the concern of disenfranchising volunteer community leaders. Although liability insurance can provide some protection to volunteers, it's the content and tone of the legislation that has a potential to threaten some of the viability of volunteer community leaders, who give their time, energy and expertise in order to improve the quality of life for seniors. Best-practice governance models stress the importance of boards governing and not managing. This legislation forces boards to be involved in the detailed operations that are the responsibility of management. This, coupled with the significant personal liability of \$25,000 and/or imprisonment for not more than 12 months, will create barriers for the recruitment and retention of high-quality volunteer board members. For example, if a person would like to volunteer to sit on a board, they may be more inclined to sit on the board of a hospital, where there is less personal liability.

Therefore, our recommendation is that the volunteer community board members in the non-profit long-term-care sector be afforded the same respect and protection as hospital counterparts under the Public Hospitals Act.

Again, as you've heard in several submissions today: the concerns for resident and staff safety. We certainly concur with the Ministry of Health and Long-Term Care that residents' rights are paramount. However, there has to be also consideration for the collective rights of all residents and staff to live and work in a safe and secure environment. For example, a resident may have refused to allow staff to use a mechanical aid in lifting as it infringes on their rights. However, that puts the staff person at risk for injury.

Again, the safety concern related to the approval process for the use of the secured unit: Homes are faced with an increase in residents with disruptive, high-risk behaviours. We agree there should be an appropriate decision-making process; however, it's important that health professionals are left with options that are available quickly to ensure safety for all.

Again, our recommendation is that a balance be found between the individual rights of residents to refuse measures to address potential disruptive or high-risk behaviours and the collective rights of residents and staff to live and work in a safe environment.

I'm going to ask Marianne to give us examples of some of those issues that we've brought forward.

**Ms. Marianne Walker:** If we go to the first issue about taking staff away from the bedside, even for our organization because we have over 700 beds, we looked at how much it would cost to train. We're not sure exactly from the legislation because it's not detailed what needs to be trained, we just sort of have the headings, but let's take one day of training. We have to take those staff away, so per 100 employees, you're talking about \$16,000 to \$20,000, depending on the rate of pay. That's going to have significant impact if that has to be absorbed. Mind you, the training needs—we believe that

those are the requirements. At the same time, looking at how we get some standards about the training that's required throughout the province so that each home isn't different and how we get together so that each home isn't taking those resources to develop those programs. So that's important.

The other thing, about the safety risk about the secured area, it's great news to hear in the legislation that we're going to get good data, good information about people coming in. That's very important to us and we're happy to see that. Where our issue lies is related to the residents who are already in the home and their behaviour deteriorates. How do we move them to the secure area quickly? This is about when the substitute decision-maker—we've had this and I'm sure others have—has said, "No, I don't want my loved one moved. I don't care if they get hit by a car." That's not acceptable for our sense of making sure that person is safe. So the issue is to ensure, if we're going through the rights adviser, etc., that there's a speedy process. What is the timeline of getting those approvals completed? That's the key: to ensure that the health professionals who have already assessed the person needing that type of care can do their job and make sure that all the residents are safe, including the one who needs to go to the secured area.

**The Chair:** Thank you. We have a minute and 20 or 25 seconds per party. We'll start with Ms. Martel.

**Ms. Martel:** Thank you very much for your participation here today. Can I just focus on your last point—a timeline? Do you have any sense of what that might be, given that you've had this experience?

**Ms. Walker:** Sometimes it's in hours that we need the answer.

**Ms. Martel:** I appreciate that. You also said that in October the board received an internal report on disruptive behaviour. Can I just ask what prompted that and what your results were in terms of what your needs are now?

**Ms. Walker:** At the initial stages we looked at the Casa Verde report and the coroner's report. Because we have quite a few organizations, including our affiliation with acute care and mental health, we brought a team together to look at all the things we should be doing to lessen the risk of this type of behaviour. I think there are about eight recommendations from that steering group, and now we're looking at how we implement it—from assessment to what do you do when it happens, training of staff, etc. There's quite a list of items.

**Ms. Martel:** This is on your own initiative. Have you costed that out?

**Ms. Walker:** No. We're still working through that process. Actually, because of the freezing rain we didn't get to meet this week. We would have known; so we're working through that.

**Ms. Martel:** I appreciate that.

**Ms. Smith:** It's nice to see you again, Marianne. Thanks for coming. I had two things I wanted to talk about: one, the secure unit and the consent question. The act does say that they shall promptly notify, that the

rights adviser shall promptly give the resident written notice. So the legislative framework is that rights advice be given promptly. However, I did want to assure you, as I did with the previous presenters, that the Health Care Consent Act still applies. So if you're in a crisis situation, then a resident could be placed into the secure unit or measures could be taken to ensure the safety of the resident and the other residents, and the rights advice and rights provisions would then apply shortly thereafter. You do have that ability still with the Health Care Consent Act to take immediate action if it's necessary. So when you say "a matter of hours", you can do that.

1510

I was interested in something in your presentation where you talk about—and I know, Marianne, you just noted that the admission provisions allow for assessments and further information being provided, but you had a concern about the constraints on the flow of pre-admission information through privacy legislation. Can you just elaborate a little bit on what your concern is there?

**Ms. Walker:** Yes. I guess what we're getting at is, looking at the coroner's report in the Casa Verde case, I think there was some information withheld by the physician that did not come forward. So how do we ensure that information is brought forward? Actually, that's one of the areas where our group that's looking at it has concern. We're looking at even doing many mental health assessments ourselves before the person actually comes to the home for that reason, if someone is keeping that information because of the privacy.

**Ms. Smith:** Right. Certainly in light of Casa Verde—that's why we drafted subsection 41(4) in the way that we did, recognizing that we needed to do an assessment of the individual's functional capacity, requirements for personal care, their current behaviour and their behaviour during the year previous. So we're looking at not just how they've been the last week or so but what their behaviours have been so that you can better prepare and determine the needs.

**Ms. Walker:** Would this legislation then allow us to get all the information from, for example, the physicians or psychologists or psychiatrists who are seeing the residents?

**Ms. Smith:** I'll get back to you on that.

**The Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation. I can certainly attest to the fact that the St. Joseph's Health System in its different locations gives outstanding, quality care. I really do appreciate your presentation. I think your presentation speaks to the fact that you're always looking forward, trying to be proactive in responding to the needs of residents and new legislation that might be introduced.

You've indicated your concern about the use of volunteer community leaders and the fact that they might be disenfranchised. So you are then recommending that they would be under the same type of provisions as the Public Hospitals Act and that would adequately address your concerns. I appreciate that.



The other issue is that you indicated here that that collective rights of residents and staff need to be considered and the fact that families also have some sort of responsibility. Could you expand on that?

**Ms. Lord:** Marianne?

**Ms. Walker:** Sure. We've actually experienced that throughout our organization, where a resident said, "My bill of rights tells me I can determine the plan of care, and I do not want that mechanical lift used." It was quite a bit of time working through that, to say, "No, we've got to also look at the risk to the staff." The ministry certainly recognizes that when they give us money for the mechanical lifts, which was greatly appreciated. It has made a positive difference. So those are the things that we're concerned about. There are the safety issues, or—and we've had this also—where a resident believes, "It is my right to bring whatever I want in the room or do whatever I want, with loud music," while the other residents are upset about it. So it's getting that balance. Certainly the legislation talks about that they—I'm sorry, I can't remember the exact clause, but talks about that they can be more forceful in enacting it. We take the bill of rights very seriously, but our issue is how we ensure the collective good of all the residents and staff and families.

**Mrs. Witmer:** Maybe the legislation needs to be reconsidered in order to make sure that balance is there.

**Ms. Walker:** That's right.

**The Chair:** We're out of time. Thank you.

#### CAW ONTARIO HEALTH CARE COUNCIL

**The Chair:** The next presentation is from the CAW Ontario Health Care Council.

Not wishing to be repetitive, but if you would state your names for Hansard.

**Ms. Darlene Prouse:** Darlene Prouse, president of the Ontario Health Care Council. To my right is Robert Buchanan, the national rep and liaison with the Ontario Health Care Council.

I thank you for the opportunity to speak to the standing committee. The importance of the legislation and necessary amendments cannot be overstated.

Our union is deeply committed to ensuring that dignity of work and quality of life exist in Ontario's long-term-care facilities. In Ontario, the CAW represents approximately 9,000 nursing home workers across 85 homes. These homes are both for-profit and not-for-profit. Many of these homes are in the southwestern Ontario region.

The CAW Ontario Health Care Council, three years ago, began a dignity campaign for long-term-care workers and residents. Its policy statement was that seniors in Ontario long-term-care facilities are entitled to quality care delivered with respect and dignity. It also recognized that we needed to create a culture of equality and dignity for all. It also showed that there was a direct causal link between quality care and staffing levels in nursing homes, recognized an increase in heavy-care residents—residents with dementia—and recognized that the staffing

levels have fallen dramatically while absences because of illness and WSIB injuries are at an all-time high.

Although we applaud the effort of many of the proposed aspects of Bill 140, we feel that the most fundamental aspect is not included; that being the reinstatement of a minimum-hours-per-day nursing standard. At times during that campaign, there were 60,000-plus postcards and petitions presented supporting the implementation of 3.5 nursing care hours per day in long-term-care facilities.

Our position reflected an interim standard that accepted further evaluation as the appropriate staffing standard to ensure optimal care for residents in Ontario. Funding would be based on the staffing levels and costs required to deliver quality care. It also reflected on the need to ensure that any funding enhancements for nursing and personal care are directed to hiring front-line staff and not used to reduce deficits.

In December 2006, the CAW Ontario Health Care Council began a second campaign, with high priority again being given to the issue of minimum standard of hours per day. Long-term-care workers continue to tell us of working short and poor working conditions and increased workloads.

Included in this document you will find a list of actual hands-on nursing care hours. The council does yearly updates on the CAW long-term-care facilities for comparisons on the actual nursing care hours per day. You will find the April 2006 report with comparisons made in those that reported to the actual hours in 2004. When you look at it, you will notice that most that reported in 2004 have had an actual decrease in the hours per day or a minimal increase, compared to the 2006 hours per day. Of particular interest, of course, is the fact that during that period of time was the implementation of the 24/7 RN and the two baths per week.

Of note as well is the fact that these hours are based on regularly scheduled shifts. They don't take into account the long-term-care facilities with policies regarding replacements of staff only after the second or third absence. This places workers and residents at risk and provides difficulty in providing quality of care.

A minimum staffing standard is a means of providing accountability from both the provider and the government in their insurance to provide adequate and appropriate staffing.

A staffing standard must have the ability to provide those residents with less individual nursing care needs with a minimum number of hours per day and to provide those with increased acuity and nursing care needs the variability to provide the maximum quality of care required. The inclusion of the minimum nursing standard would ensure that the Long-Term Care Homes Act would provide the residents of long-term-care facilities with the best possible level of care.

**Mr. Robert Buchanan:** My name is Robert Buchanan. I'm national rep with the CAW and I service mostly long-term-care facilities in southwestern Ontario.

Experience has taught us that the need for minimum staffing in nursing and personal care is required in long-

term-care facilities. For far too long have residents in these facilities been put in vulnerable situations because there is no minimum staffing requirement.

Governments and policy-makers have recognized the fact that we need to have minimum standards. We have a minimum standard for wages, we have minimum standards for health and safety and we have minimum standards for food preparation, but we don't have minimum standards for nursing and personal care. And let's not forget: We once did have a minimum standard in this province but it was removed in 1996 by the Conservative government. Elderly people living in long-term-care facilities need to have proper care, and that can only be done through having a minimum standard. Otherwise, they're put into vulnerable situations.

1520

I'm going to give you two examples of vulnerable situations where our members were put into serious situations, and so were the residents.

The first happened in May 2005 at Extendicare London. Extendicare London announced to the union in early spring that they were going to cut 28 hours of strictly nursing and personal care—not other services—out of the home. That amounted to 200 hours of nursing and personal care, the equivalent of five full-time care providers, that were cut from the home. These cuts were directed at the front-line care providers—PSWs, personal support workers, and RPNs, registered practical nurses—the people who actually do the hands-on care.

These cuts were made despite the same number of residents living in the home. I can assure you that for-profit nursing homes don't overstaff. Their interest is in making money for their shareholders and providing a service, and they do that at the bare minimum. These cuts had a tremendous effect on the quality of care and the quality of work at Extendicare.

What happens also in these situations is that our members are put into vulnerable work situations because they feel they have to get the work done that they normally would have done with additional staff. So it puts them in a vulnerable situation.

The second circumstance happened at Woodingford Lodge. The county of Oxford runs three nursing homes in Ingersoll, Tillsonburg and Woodstock. In October 2005, 112 hours were cut from nursing care in the two satellite homes. Six months later, 900 hours were cut out of services provided to the residents at Woodingford in the Woodstock area. This resulted in direct front-line care to residents dropping below two hours per day per resident. And this is not just a resident issue. The front-line workers were also involved in situations that resulted in WSIB injuries increasing from 12 just before the layoffs in July to 22, doubling the WSIB injury incidence.

Furthermore, one of the most odious policies that I believe nursing home operators are doing is purposely allowing the floors of nursing homes to be short-staffed. What happens is that typically someone may call in sick, the employer won't replace that person, and in many cases the employer won't replace them until after a

second person has called in sick. This results in the home being chronically understaffed and the floor usually running short.

We've chosen these examples because we believe that if there were a minimum staffing requirement, we wouldn't have had these problems in the first place. Without minimum staffing in nursing and personal care, owners in public, private, profit or not-for-profit will continue to staff at unacceptable levels. A minimum standard would ensure that each resident is guaranteed the dignity and care they deserve.

Thank you very much for the opportunity to speak.

**The Chair:** Thank you very much. We have about a minute and 25 seconds per party, and we will start with the parliamentary assistant.

**Ms. Smith:** Thank you. We've heard a great deal about the minimum standard question. I'd just like to ask you whom you would include in the calculation of your minimum standard.

**Mr. Buchanan:** Are you asking that to me or to Darlene?

**Ms. Smith:** Either one; both.

**Ms. Prouse:** You'll see by the survey that it's the actual hands-on care, which would be your RPNs, RNs, PSWs, health care.

**Ms. Smith:** Do you include in that number the director of care?

**Ms. Prouse:** No.

**Ms. Smith:** But you do include the RN.

**Ms. Prouse:** Yes.

**Ms. Smith:** Would you include in that number a dietary aide who was feeding? Right; that was no?

**Ms. Prouse:** Yes.

**Ms. Smith:** Thank you for being here.

**Mrs. Witmer:** Thank you very much for your presentation. I think the point has been well made that there does need to be some sort of reinstatement of minimum hours per day of nursing care. We do appreciate the concern that your members have to make sure that residents do receive hands-on touch care. Thank you.

**The Chair:** Ms. Martel.

**Ms. Martel:** It would have been great if they had never been cancelled in the first place—I guess I just have to add that—in 1996.

In any event, let me look at your survey. If I read this correctly, you're saying that there has been a decrease in care in most cases or a very minimal increase two years after. So the 2006 figures are actually worse in most cases than the 2004 figures. Is that correct? Am I reading this right?

**Ms. Prouse:** Yes.

**Ms. Martel:** Added to that, if I'm also reading this right, is that your numbers were based on regularly scheduled shifts, but we have heard from so many people that most people are not working—there's not a full complement most of the time. In fact, people are working short-staffed. So if we actually were looking at the real hours that had been worked, the situation probably would be worse. Correct? I've been advocating for a long time for 3.5 hours of hands-on care per resident per day as a



minimum. I am encouraging the government to at least live up to the promise that they made, which was to reinstate 2.25 hours. I think it has to be higher than that, given acuity. I think you have very clearly shown with the figures that you've given us why it is imperative that there be a standard in place that has to be met. Further to that, you can have the standard, but you need the money to hire the staff to go with it, which is why the government has to live up to the second promise of \$6,000 per resident per year.

I appreciate very much your giving us these figures, which show what's going on in the homes that you represent, and clearly what's going on in too many cases is a worse situation now than it was two years ago, and that's really regrettable. Thanks very much.

**The Chair:** Thank you for your presentation.

### STEEVES AND ROZEMA NURSING HOMES

**The Chair:** The next presentation: I apologize if I mispronounce it, but I believe it's the Steeves and Rozema Nursing Homes.

**Ms. Joyce Haneca:** Yes; Steeves and Rozema. My name is Joyce Haneca.

**The Chair:** Thank you. Fifteen minutes.

**Ms. Haneca:** Good afternoon. I am currently an administrator with Steeves and Rozema Nursing Homes in Sarnia, Ontario. I've had the privilege of working in long-term care for the past 18 years. I started out as an office manager for 14 years at Chateau Gardens here in London. It was a 63-bed nursing home, which was a not-for-profit, that appealed to receive D-classification status and subsequently rebuilt. I worked for two years as a ward clerk at Sprucedale Care Centre in Strathroy and I was with them during their recent rebuild with the capital renewal funds as well.

First of all, I understand that a lot of work was involved in writing this new long-term-care act. I am sure it was laborious to amalgamate the three existing acts that were written so long ago. This update has been necessary, and I applaud your efforts thus far. If history is an indicator, once this bill is passed and this act is legislated, it will be the final word on long-term care for many years to come, although I'm not sure that this is really the legacy that you want to leave.

You have had the opportunity of hearing five full days of presentations regarding the new long-term-care act. Since I was originally slotted on the agenda as the last presentation for today, I thought I needed to come up with something very creative and something that would catch your eye: I thought I would be known as the closer. Since then, the agenda has been amended and I'm not the closer, but I'm going to pretend I am. I want to say to you that, because of the nature of this act, I hope this government does not want to be known as the closer of long-term care as we know it today.

All I ever wanted was to become an administrator. I had worked in roles that allowed me to grow but did not give me the chance to effect change. I wanted that opportunity, so I obtained the necessary education, and

after graduation I was offered my current position. Now that I am an administrator, after reading the new long-term-care act, I'm not sure that this is what I want to do. The act promotes an environment of blame, which seems not only onerous but defeating.

1530

I had written our Premier Dalton McGuinty about these concerns. His response was very complimentary. I'll quote you from his letter to me:

"You never fail to care for them"—meaning the residents—"with professionalism, skill and compassion." If this is how our government leaders feel, why is the new act so punitive towards operators and licensees?

As a new leader in this field, I can assure you that there is not a lineup of candidates at my door waiting to work in long-term care. Aside from the inherent stigma that it is a depressing workplace, there is the ongoing message that we are out to make a profit without any care or concern for the residents' wellbeing. If the government is truly convinced that the majority of care providers are good at their job, why is Bill 140 so harsh? In this industry, we are already faced with a severe shortage of professional staff. This act, if it is not revised, will only drive the potential workforce further away from this line of work. No one in their right mind will voluntarily go to work where they have the potential to be ticketed during the course of their duties.

I agree that there should be a method to address abuse, neglect and poor management in any long-term-care home, but this process should not be so cumbersome that it prevents diligent operators and administrators from providing caring, home-like environments. This act has the potential to dehumanize our home and push it into an institutional atmosphere that we have been desperately trying to avoid. Instead of being able to focus on the residents and their wellbeing, we will be busy ensuring that we have dotted every "i" and crossed every "t."

Many people have come before you and addressed a variety of specific issues throughout the act. You have heard the concerns regarding licensing, restorative care, increased paperwork, lack of funding, and on the list goes. I know that you have heard them all and I will not sit here and regurgitate them for the last time. But I would like to invite you to come with me, take a step back, and let's look at Bill 140 in a more global fashion.

There are three stakeholders identified in this act: the minister and/or ministry, where "'minister' means the Minister of Health and Long-Term Care," the director is the ministry's appointee, and a resident is identified as any person "living in a long-term-care home." Then there is the licensee, who is identified as the "holder of a licence issued under this act." In essence, the purpose of the act is to clearly define the rights, responsibilities and accountabilities of each of the stakeholders. So we have established the three primary participants involved in this act.

I ask you to bear with me. Ethics requires the following four cornerstones to be met: beneficence, non-maleficence, justice and fairness. Due to our limited time, I will not dwell on the first two terms, but I would like to

address “justice” and “fairness.” The term “justice” is defined as “The principle of moral rightness; equity ... especially fair treatment and due reward in accordance with honour, standards or law.” The term “fairness” is defined as “Free from bias, dishonesty or injustice.”

Justice and fairness for all the primary stakeholders are essential for this act to meet ethical standards. In raw terms, this would mean that the rights, responsibilities and accountabilities of each party are clearly stated. I truly believe that this is the core issue that has caused so many people to step forward and voice their concerns. The heart issue is that there is no delineation of the rights, responsibilities and accountabilities of all the players.

Part I, section 1, states:

“1 The fundamental principle to be applied in the interpretation of this act and anything required or permitted under this act is that a long-term care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort.”

Part I, section 1 clearly identifies the rights of the residents, which it should, which are further supported in the residents’ bill of rights. So if it is truly the residents’ home, why does the ministry have the right to determine what is posted on the walls? And where are the residents’ responsibilities to participate with the plan of care or meet their financial obligations or even enter into a contract with the licensee? With rights, there must be responsibilities.

The responsibilities of the licensee are clearly defined throughout the act, and I want to use section 17 as an example: “Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.” Long-term-care licensees have been leaders in zero tolerance for resident abuse. We recognize this as our responsibility, but this statement does not identify the licensee’s right to receive or the ministry’s responsibility to provide adequate funding for staff to prevent neglect. How can the licensee be held responsible when a government arbitrator reinstates a staff member who has been discharged from their duties for resident abuse? The licensee has been stripped of their right to address abuse issues.

If a licensee is responsible to protect the resident from financial abuse, the act does not state that there are any responsibilities of the resident or the power of attorney to co-operate with either the ministry and/or the licensee to address financial abuse issues, so how can the licensee be held responsible for something they have no right to enforce?

Again, if it is the resident’s right to be properly sheltered and fed, should it, then, not follow that it is the ministry’s responsibility to provide adequate funding to feed the resident? It is the licensee’s responsibility in the act that their home meets the operating standards set out by the ministry. If that is the licensee’s responsibility, then where is the ministry’s responsibility to provide the necessary funds, and where is the licensee’s right to have their licence protected to ensure their operating viability?

Although there is a suggestion that a capital renewal and retrofit program for B and C homes is not a Bill 140 issue, it has become a legislation issue because the licence has been tied to the structural requirements of the home as outlined in the regulations. There is no justice in a system that requires a licensee to meet standards that it cannot meet without the ministry’s responsibility to provide capital funds.

The ethical cornerstone of fairness is sadly lacking in this act. The act is not free from bias. It has a punitive framework towards the licensee, imposing sanctions, work orders, tickets as deemed necessary by the minister. Again, these are the licensee’s responsibilities, but where is their right, like any common criminal, to be considered innocent until proven guilty? Why is the onus and burden of proof put on the licensee? This framework violates one of the essential components of ethical treatment, and that is fairness.

I could go on and on and give many more examples from this act that would support this view, but suffice to say that this piece of legislation as it stands is an ethical quagmire, and it is opening the door to further abuse of an already beleaguered system.

So where do you go from here? After we have completed these presentations and we all go home and to our offices and you have all returned to your desks, what is the final outcome? What needs to happen? Well, I’ll make it easy. It’s as easy as ABC:

(a) admit that there need to be adjustments to this act as it is currently written;

(b) build into the act an ethical framework which includes the rights, responsibilities and accountability of all stakeholders; and

(c) commit to the capital funds required to provide for the rights of these residents.

Thank you for your attendance, your attention and your interest as we all work together to provide for the future of our valued seniors.

**The Chair:** Thank you. One minute per caucus, starting with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Joyce, for your presentation. It was certainly very enthusiastic. I was quite moved to hear you say that all you ever wanted to be was in charge of a long-term-care home. That’s an interesting dream to have.

You’ve done an outstanding job. I think you’ve taken a look at the bill from a different perspective than what we’ve heard today, but I think we would all agree with you that certainly the whole issue of fairness is lacking in this legislation. If you had one thing to say to the government, one thing they needed to change to at least help to get it right, what would it be?

**Ms. Haneca:** I would love to be able to summarize it in one thing, but I think that’s next to impossible. This act cannot be passed as it stands, and there has to be a commitment to funding.

1540

**Mrs. Witmer:** Thank you very much.

**The Chair:** Thank you. Ms. Martel.



**Ms. Martel:** Thank you for your presentation this afternoon. As an administrator, in looking through the provisions of the bill—because there are increased responsibilities—have you been able to put any kind of costing towards that? I'm thinking in terms of human resources to actually ensure that you comply with all of the reporting requirements that are here.

**Ms. Haneca:** All I can speak of—because we don't know what the potential will be, but I can speak from experience. Any time the Ministry of Health is coming in to do either a complaint investigation or to follow up on a compliance issue, I can pretty well guarantee that my time and all of my manager's, and even front-line staff—because we just had this happen recently; up to five days of each of those people. So you're looking at maybe 20 days of staff time tied up in putting together a compliance plan, making sure that you can effect it, making sure it works—and we want to meet these standards; we want to go beyond these standards. But the onus and the burden is so high, and that's just an amount of time where I'm shutting my door to concentrate on that work. I'm not interacting with the residents or their families, and if they don't change the act as it stands, there's just going to be more of that. It's a real shame, because the whole point of my wanting to be in the business I am is to provide for the residents, not complete more paperwork.

**The Chair:** Thank you. Parliamentary assistant? No. Thank you.

#### CINDY RUDDY

**The Chair:** That brings us to our final presentation, which is Cindy Ruddy.

Welcome.

**Ms. Cindy Ruddy:** My name is Cindy Ruddy. I am employed at Elgin Abbey Nursing Home in Chesley, and I am also a member of the Service Employees International Union. I'd like to take this opportunity to thank you for allowing me to come and speak today.

I did not prepare a brief ahead of time, as I just decided that I would rather present my concerns with a few notes, kind of wing it and go by the seat of my pants, which I'm known to do, and speak more from the heart. What I'll be discussing today is the current condition of the staffing complements that have been overlooked in Bill 140.

Two patients limp into two different Canadian medical clinics with the same complaint. Both have trouble walking and both need a hip replacement. The first patient is examined within the hour, is X-rayed the same day and is booked for surgery the following week. The second sees the family doctor after waiting a week for an appointment and then waits eight weeks to see a specialist, then gets an X-ray which isn't reviewed for another month, and finally has surgery scheduled for a year from then. Why the different treatment for the two patients? The first is a golden retriever, the second a senior citizen.

I'm not trying to make light of a very serious situation; however, I wanted to point out that we hear many, many

jokes about our health care system and how the flaws associated with it make it easy to poke fun at. We rarely, rarely hear jokes about long-term care, and the reason for that is that unless a loved one requires long-term care, there really is no reason to think about it. As a result, people are completely uninformed of how we, the health care providers, the seniors living within the facilities and their families are left to deal with such an underfunded health care component within the Ministry of Health and Long-Term Care system.

The facility that I work in operates on 2.45 hours of nursing care per resident per day. This is simply not acceptable. I'm not going to reiterate what has already been addressed. You are all well aware of the way the CMM works and how the funding is determined. I'm going to use my time today to describe how this system is failing and why our seniors are considered to be the Ontario government's forgotten.

They're at the post. This is where I wing it. Every day, staff members come to work, and that is exactly how their day starts: They feel like they're horses, and the gate is going to flood open and rush in. It is that way almost every single day. It's overwhelming, it's stressful and completely unnecessary. They spread themselves so very thinly that they leave exhausted every day and wonder if it is going to be any better tomorrow, only to find out tomorrow that it isn't. Like I said, we're rushed.

As I look around, I'm assuming that pretty much everybody here has children. What I like to compare it to is when you get up in the morning and your alarm has not gone off; you're rushed, and you get your kids and whip the clothes on them, only to find out that their socks are inside out and they don't want to work with you. They don't want cereal for breakfast; they want a slice of bread. It goes on and on and on. That is a very sad thing; you know yourself how you feel when you leave. You think, "Oh, that was so terrible. Why did I rush them through that? That was not right." But you had to; in order to get done what you needed to get done, you had to rush. That is exactly what we deal with every day, on a daily basis.

We have families who wish to speak to us, the front-line workers, not the people sitting in their offices. They want the front-line workers. That takes time. You cannot overlook the family members, who need to know that their loved one is being well looked after. They want to speak to us, who deal with them every day. So you stop and you take the time. You are now 10 minutes behind. You were already 15 minutes behind. Now you're 10 minutes more behind.

About eight years ago, a colleague of mine said to me, "You know, Cindy, we do 10 hours of work in eight, and we're expected to do it in seven and a half." She's now retired, and I'm expecting to probably see her in a nursing home some day. I feel sorry for her, because I know how frustrated she will be when she gets in to find out that things have not changed in all those years—things we don't have time for, like cutting nails, something simple that you would probably take for granted. You jump in a bathtub; you clip your nails; you're done.

These people have to wait, and if they don't get done, what happens when they get aggressive? We get scratched. But you have to take priorities and you have to do what is necessary and what is important. There's no time for one on one, to sit, to hold a hand, to talk. That's pathetic. A hug, backrub—we all like backrubs. That was what we did years ago when I first started. I've been there a lot of years; 27, I think, to be exact. We did that; we used to do backrubs. You very rarely see that any more.

**Toileting:** This is my pet peeve. We have diaper police. I'm sure you've heard this. You wear your Depends until it is 75% wet. I brought one with me today with water in it. That is a wet diaper. It holds this much water. That's what's in there. If it is not 75% wet, we are expected to take it off, wash them, and put it back on. Would you ever consider doing that to a child? But we're doing it to our seniors. That is disgusting; absolutely disgusting. As a result, staff feel like they've let the residents down, which we have, and we deal with that every day. We have what I call the Florence Nightingale syndrome, and that is, we're all nurturers; that's what's keeping our residents well looked after. It's because that's what we do. We don't care that we've been there eight hours or eight and a half hours. We're there to make sure they're looked after.

I have this feeling—everybody I talk to says the same thing: They're all very, very stressed and very tired.

We have Alzheimer's residents who constantly repeat themselves during the day, which is interesting, because you hear the same story every day. That's part of the job. But they still want you to stop and listen. Even though I know it verbatim, they still want you to listen. There are elopers and aggressive people. One person could walk out the door 10 times in five minutes, but you have to go out and bring them back in. That's not personal care; that's just caring for them. For stroke patients with paralysis, their comprehension level is down. They don't understand you, so you are repeating yourself over and over again. Sometimes it takes a while for what you're telling them to reach their brain and for them to understand, so you have to sit and wait. You can't just say, "Here," and they take it. You see that their brain is slow, but you must wait. That's all time-consuming; very, very time-consuming.

**Mental illness:** We have some people who have mental illness. We have one gentleman in there right now who calls me, "Mommy." So I go to work every day and I'm still hearing, "Mommy, I'm wet." These are everyday things that occur within the facility.

1550

What "care" stands for at present: "C" stands for challenges that we meet every day. "A" stands for agnosia, which is lack of recognition of people. "R" stands for resistance from the ministry for additional funding. "E" stands for exertion and exhaustion.

What "care" and "long-term care" should stand for: "C" is for commitment and continuity from everyone, including the Ministry of Health and Long-Term Care. "A" is for accountability from all disciplines which actively

participate in our elderly population, including the ministry, which establishes and sets the standards for all parties to achieve. This should include the allowances of the appropriate and necessary funding requirements for all long-term-care facilities. "R" is for revolutionary. Giving support and allowing the staff and residents the time to interact more will enhance and allow the development of more specific and individualized programming. This would ensure that our residents' needs and desires are enhanced. After all, this should be the ultimate goal of all disciplines. We all know how important it is to us that while at home we can be ourselves. The older we get, the more support we need to reach this desire. Our staff need the time to help our residents. "E" is for enabling choices. They don't have choices. It's very sad.

It is undeniable to say we are faced and confronted with challenges on a regular basis. This is interesting: I have personally—and you wonder why I cry, but I love my job—been slapped, kicked, punched, pinched, bitten, spat at, yelled at, sworn at, urinated on, vomited on, defecated on and, in the next breath, hugged, kissed, been confided to. I've cried with, laughed with and grieved with many, many residents over the years. We are fortunate to have so many front-line staff who appreciate our elderly for who they are and what they represent. As you are well aware, it is becoming more challenging to recruit this type of person for our elderly to rely on. It is imperative that we recognize the importance of the commitment required to maintain those we have and make it more appealing for potential employees. Our government needs to realize that our seniors deserve to be given the privilege of the support, the dignity, respect and care they are so rightfully deserving of. It is time to care for those people who have taken care of others for so long, including each and every one of you.

I acknowledge that not every resident requires the same care. That just goes without saying. However, there must be a benchmark that must be established to ensure a minimum amount of care. In the United States, a study commissioned by the Federal Centers for Medicare and Medicaid Services identified three staffing thresholds below which the quality of care was found to suffer. The threshold is 45 minutes for RNs; one hour, 18 minutes for total licensed services—RNs plus RPNs; and two hours and 48 minutes for PSWs. Any nursing home that meets these standards would provide at least four hours and six minutes of total nursing care per day. I implore you to amend Bill 140 to reflect the 3.5 hours of hands-on care per resident per day. That would be a major, major contribution to help ensure that this standard is met. Thank you.

**The Chair:** Unfortunately, there is no time for questions, but thank you.

That concludes the public hearings for Bill 140. The committee will meet next Tuesday to commence clause-by-clause deliberations. The committee is now adjourned.

*The committee adjourned at 1556.*



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Ms. Shelley Martel (Nickel Belt ND)

Ms. Monique M. Smith (Nipissing L)

Mrs. Elizabeth Witmer (Kitchener–Waterloo PC)

### **Also taking part / Autres participants et participantes**

Mr. Ernie Hardeman (Oxford PC)

### **Clerk / Greffier**

Mr. Trevor Day

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Second Session, 38<sup>th</sup> Parliament

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**Official Report  
of Debates  
(Hansard)**

**Tuesday 30 January 2007**

**Journal  
des débats  
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**Standing committee on  
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Long-Term Care  
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**Comité permanent de  
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Loi de 2007 sur les foyers de  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Tuesday 30 January 2007

Mardi 30 janvier 2007

*The committee met at 0931 in committee room 1.*LONG-TERM CARE HOMES ACT, 2007  
LOI DE 2007 SUR LES FOYERS DE SOINS  
DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

**The Vice-Chair (Mr. Khalil Ramal):** Good morning, ladies and gentlemen. It's about 9:30 on Tuesday, January 30, 2007. Welcome back to the social policy committee. Scheduled for today is clause-by-clause consideration of Bill 140, An Act respecting long-term care homes.

The clerk suggested that I read this: "When a bill is considered in a committee, the Chair shall enquire whether any comments, questions or amendments are to be offered and to which sections and will call only such sections. If no sections are so designated, the bill shall be reported as a whole."

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** I have submitted my amendments.

**Ms. Shelley Martel (Nickel Belt):** I have submitted my amendments as well.

**Ms. Monique M. Smith (Nipissing):** We have submitted our amendments as well.

**The Vice-Chair:** We'll start with section 1, and the NDP.

**Ms. Martel:** I move that section 1 of the bill be amended by striking out "may" and substituting "shall."

This is in the fundamental principle and interpretation part of the bill. The fundamental principle is clear that a long-term-care home is the home of its residents and it's to be operated in a way to guarantee their safety and their comfort and their dignity, and I think we send a much stronger message that we are committed to that by removing the word "may" and making it clear that they "shall."

**The Vice-Chair:** Further debate?

**Ms. Smith:** We oppose this amendment. We think that "may" gives the flexibility to the residents to do as they choose. "Shall" would be requiring a resident to live in a certain way. We think "may" allows them to live as they choose, which is the fundamental principle of this legislation: that it be resident-focused.

**The Vice-Chair:** Further debate? Are we ready for the vote?

All those in favour of the amendment? Opposed? It's lost.

Amendment number 2, by the NDP.

**Ms. Martel:** I move that section 1 of the bill be amended by adding "and have their physical, psychological, spiritual and cultural needs met" after "comfort."

This amendment was proposed by the Ontario Health Coalition, by OPSEU and by CUPE. It further strengthens what we anticipate residents should be entitled to have and to expect when they live in a long-term-care home.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** If Ms. Martel is amenable, I propose a friendly amendment to that: "That a long-term care home is primarily the home of its residents"—so we would add the word "primarily"—"and have their physical, psychological, social"—add the word "social"—"spiritual and cultural needs adequately met."

**The Vice-Chair:** Any further debate?

**Ms. Martel:** That's fine with me, Chair.

**The Vice-Chair:** We need an amendment to the NDP amendment.

**Ms. Smith:** Okay. I move the following friendly amendment. That section 1 read:

"The fundamental principle to be applied in the interpretation of this act and anything required or permitted under this act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort, and where their physical, psychological, social, cultural and spiritual needs are adequately met."

I have moved that as an amendment to motion number 2.

**The Vice-Chair:** Can you move it and write it?

**Ms. Smith:** In writing—sorry?

**The Vice-Chair:** Yes, in writing.

**Ms. Smith:** I move that section 1 of the bill be amended by adding the word "primarily" after the words "long-term care home is."

**The Vice-Chair:** Further debate?

**Ms. Smith:** Sorry, I wasn't finished.

**Mrs. Witmer:** Is that not government motion number 7?

**Ms. Smith:** It is.

**The Vice-Chair:** Keep going.

**Ms. Smith:**—by adding the word “primarily” after the words “long-term care home is” and by adding “and have their physical, psychological”—and here I’m adding the word “social.” Sorry—“physical, psychological” and then I’m adding the word “social,” “spiritual and cultural needs are adequately met.” I’m adding the word “adequately” after—sorry, “needs are adequately” and after “comfort.”

**The Vice-Chair:** Do you mind reading it again, all together?

**Ms. Smith:** I move that section 1 of the bill be amended by adding the word “primarily” after the words “long-term care home is” and by adding “and have their physical, psychological, social, spiritual and cultural needs adequately met” after “comfort.”

**The Vice-Chair:** Thank you. Is there any further debate?

**Mrs. Witmer:** If we’re going to make an amendment here, I do believe we have to add “and is to be operated and funded.” There is no reference made in section 1 of the bill whatsoever to funding, so I could not accept this change without a recognition of the fact that it’s not just operation but also, in order for this to happen, there is going to have to be government funding provided.

**The Vice-Chair:** Any further debate on the amendment submitted by Ms. Smith to the NDP amendment number 2? No. I put that amendment for a vote. All in favour? Those opposed? That carried.

Now I want to deal with the second NDP amendment submitted by Ms. Martel, as amended. All in favour? Opposed? Carried.

The third motion is from the Conservatives.

0940

**Mrs. Witmer:** I move that section 1 of the bill be amended by adding “and receive nursing and personal care to address their needs” at the end.

At this point in time, there is no recognition for the need to provide any nursing and personal care, and I think we want to ensure that we indeed provide what is expected to our residents. Also, if we take a look at this bill and we take a look at the extensive detailed obligations and reporting requirements, we know that staff are going to have to spend much more time on compliance and documentation rather than resident care and services. It’s simply not possible to even provide the same level of care as is currently provided, which we know is not sufficient. So unless we put in here some sort of a recognition of the need for the nursing and personal care to address their needs, my concern is that the level of time committed to care and nursing will further decline if there’s no additional government funding. I don’t want to reduce the quality of care presently being provided.

**The Vice-Chair:** Further debate?

**Ms. Martel:** I agree with Mrs. Witmer and have moved an exactly similar motion on the next page. So I agree with what she said, that we should be amending section 1 as per this change.

**Ms. Smith:** I don’t agree that we need to add this. I think it’s redundant given that we’ve just added that we

will be meeting their physical, psychological, spiritual, cultural and social needs, and I feel that that’s more inclusive. I think that this legislation actually is focusing in on the residents’ needs and making sure that those needs are met, so I don’t think that Conservative motion 3 is necessary. We’ll be voting against it.

**The Vice-Chair:** Any further debate? We’ll put the motion to a vote. All in favour of PC motion 3? Opposed? It’s lost.

We’ll move to the fourth motion, by the NDP.

**Ms. Martel:** Mr. Chair, in light of the last vote on an exactly similar motion, I’ll withdraw this amendment.

**The Vice-Chair:** Ms. Martel withdraws motion 4.

We’ll move to motion 5, also by Ms. Martel.

**Ms. Martel:** I move that section 1 of the bill be amended by adding “and is also a workplace, which is operated with due regard to the health and safety of staff of the home” at the end.

I appreciate that the fundamental principle really needs to focus on those residents of long-term-care homes in the province of Ontario, but I also think it is incumbent upon all of us to recognize that while it is a home, it is also a workplace, and many people who are providing work in that workplace to try and meet residents’ needs have to have their health and safety needs met. We heard from workers during the course of the public hearings about inappropriate or violent behaviour of residents that led to them being bitten, slapped, spit on and in some cases seriously hurt, so that they could no longer return to their regular work. I think that in the fundamental principle, we need to be also guaranteeing that workers who are providing excellent care to the residents whom we’re trying to support are able to do so under circumstances that look out for their well-being as well. Otherwise, they’re not going to be in much of a position to provide adequate care, good care, quality care to the residents. This was submitted by the Ontario Nurses’ Association.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** We believe that by amending the fundamental principle to include the word “primarily,” we are acknowledging that it is not just the home of the residents but other things, including a workplace. We acknowledge that those workers are entitled to protection under the Occupational Health and Safety Act. We don’t want to dilute from that, so we’ll be opposing this motion. We feel that through this legislation, we’re providing training. We have invested in lifts. We certainly do recognize the need for a safe work environment for our workers, and we will continue to do so.

**The Vice-Chair:** Any further debate?

**Ms. Martel:** One final point: I don’t see how adding this particular provision would in any way dilute from the Occupational Health and Safety Act. But I’ll leave it at that.

**The Vice-Chair:** Any further debate? Now we’ll put NDP motion 5 to a vote. All in favour? Opposed? It’s lost.

We’ll move to PC motion 6.



**Mrs. Witmer:** I move that section 1 of the bill be struck out and the following substituted:

“Fundamental principle

“1. The fundamental principle to be applied in the interpretation of this act and anything required or permitted under this act is that a long-term care home is the home of its residents and is to be operated and funded so that the medical, nursing, personal support, dietary, recreational, social, restorative, religious and spiritual needs of each of its residents are adequately met and that the home is a place where they may live with dignity, and in security, safety and comfort.”

I spoke to this before because we've since amended the fundamental principle, but I am concerned that the fundamental principle no longer recognizes the long-term-care home as a health service provider funded to provide care to residents—and it is absolutely essential that there be government funding—in addition to, as we already are saying, it being the home for residents. Obviously, these individuals are admitted based on their assessed needs, and currently, if we take a look, even with the amendment that we've made, there really doesn't appear to be any requirement for funding to meet the care needs of the residents, so I do believe it's important that that be there.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** I don't know that it's appropriate to be including funding motions in the legislation.

*Interjection.*

**The Vice-Chair:** It's a principle to be applied, not direct funding. Any further debate?

**Ms. Smith:** We'll be opposing this motion.

**The Vice-Chair:** Any further debate? I'll put PC motion 6 to a vote. All in favour? Opposed? The motion is lost.

We'll move to government motion 7.

**Ms. Smith:** I withdraw this motion.

**The Vice-Chair:** Motion withdrawn.

Any debate on section 1, as amended? No? Shall section 1, as amended, carry? Carried.

Now we'll move to NDP motion 8.

**Ms. Martel:** I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘abuse,’ with respect to a resident, means any action or inaction, misuse of power or betrayal of trust or respect by a person against the resident, that the person knew or ought to have known would cause, or could reasonably be expected to cause, harm to the resident's health, safety or well-being, and includes, without being limited to, physical abuse, sexual abuse, sexual assault, emotional abuse, verbal abuse, financial abuse, exploitation of person or property, neglect, prohibited use of restraints, and improper discipline, and can be either a single act or repeated acts, and can be a lack of appropriate action;”

This particular amendment was given to us by the Advocacy Centre for the Elderly. It is a broader definition of abuse, and I think it is appropriate to be sure that

we are recognizing all forms of abuse that a resident might face.

**The Vice-Chair:** Ms. Martel, just a clarifying question: Was this definition for abuse to replace the definition or just to clarify it?

**Ms. Martel:** I wanted it to replace. I'm sorry; I probably didn't make that clear to legislative counsel.

**The Vice-Chair:** There already was a definition. Do you want it repeated? Okay. Further debate?

**Ms. Smith:** It's our position that it's not appropriate to put this type of definition in the legislation itself as the notion of abuse could change over time and we would like the ability to reflect those changes or any new determination of what may fall under the definition of abuse. I would also note that in clause 178(2)(a), the act allows for regulation-making authority to define “physical, sexual, emotional, verbal and financial abuse for the purposes of the definition of ‘abuse’ in subsection 2(1).” We would hope to have some public consultation on the definition of abuse and ensure that we have a proper working definition that could be modified, if need be, in the future. That's why we would put it in the regulations. So we'll be voting against this amendment.

**0950**

**The Vice-Chair:** Any further debate? I'll put NDP motion number 8 to a vote. All in favour? Opposed? Lost.

Government motion number 9: Ms. Smith.

**Ms. Smith:** I move that subsection 2(1) of the bill be amended by adding the following definitions:

“‘care’ includes treatment and interventions; (‘soins’)

“‘incapable’ means unable to understand the information that is relevant to making a decision concerning the subject matter or unable to appreciate the reasonably foreseeable consequences of a decision or a lack of decision; (‘incapable’)

“‘intervention’ means an action, procedure or activity designed to achieve an outcome to a condition or a diagnosis; (‘intervention’)

“‘volunteer’ means a person who is part of the organized volunteer program of the long-term care home under section 15 and who does not receive a wage or salary for the services or work provided for that program. (‘bénévole’)

**The Vice-Chair:** Any further debate? If there's no debate, I will put government motion number 9 to a vote. All in favour? Opposed? None? Carried.

We move to NDP motion number 10.

**Ms. Martel:** I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘neglect’ means the failure to provide the care and assistance required for the health, safety or well-being of a resident, and includes a pattern of inaction that jeopardizes the health or safety of one or more residents, and includes, without being limited to, the failure to,

“(a) provide the ongoing care set out in a resident's plan of care,

“(b) provide access to a physician's services, when required,

“(c) reduce and manage health and safety hazards in the facility on an ongoing basis,

“(d) implement programs to identify and mitigate risks, so as to prevent and minimize health-care problems in the facility, including, but not limited to, pressure ulcers, dehydration and unplanned weight loss,

“(e) summon or provide assistance, when required,

“(f) respond to a resident’s request for assistance, or

“(g) report witnessed or suspected abuse;”

Right now, in the definition section, there is no definition listed for “neglect.” I think the proposal I’ve put forward is very broad because, as I argued earlier with “abuse,” we should be recognizing all forms and all types of both potential abuse and potential neglect. I think the amendment that I have put forward does that in terms of anything a resident might face in terms of not getting the care he or she needs in a long-term-care home. This proposal was put forward to us by OANHSS.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** I appreciate that Ms. Martel’s definition is extensive. We do have in clause 178(2)(c) a regulation-making power to define “neglect” for the purposes of any provision of the act. I think that consultation would be appropriate in this case to ensure that we have a broad definition as well to ensure that we have the ability to amend a regulation in the future, should there be something that is unforeseen that we note should be included in the definition of “neglect.”

**Mrs. Witmer:** I would support the government in the need to put this in and provide flexibility. I believe it belongs in regulation—and it does require consultation.

**The Vice-Chair:** Any further debate? If none, then I put NDP motion number 10 to a vote. All in favour? Opposed? Lost.

NDP motion number 11: Ms. Martel.

**Ms. Martel:** I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘nursing’ means care and service provided by a registered nurse or by a registered practical nurse or registered nurse in the extended class;”

This proposal was put forward to us by OANHSS.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** I note that in government motion 268 we define “nursing care” for the purposes of section 93. As well, it’s inappropriate to put in the definition of “nursing” when the college determines through the Regulated Health Professions Act what nursing is for every different class. We do, in the definition section, acknowledge the different types of nursing. So I’ll be voting against this motion. We think it’s adequately dealt with in the legislation.

**The Vice-Chair:** Any further debate? None? All in favour of NDP motion number 11? Opposed? It’s lost.

We move to motion number 12.

**Ms. Martel:** I’m going to be withdrawing this, because there is a definition later on in the restraints section that the parliamentary assistant pointed out to me, so I will agree with her and withdraw it at this time.

**The Vice-Chair:** We will move to NDP motion number 13.

**Ms. Martel:** I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘restorative care’ means an interdisciplinary approach to care provision which is designed to assist the resident to maximize his or her remaining strengths and abilities in order to attain or maintain the maximum level of functioning that is possible, or that is desired by the resident, or both;”

Again, there isn’t a definition of “restorative care” in the definitions section. I think there should be, and I think this makes it clear that restorative care also means the broadest possible ability of ensuring that the resident maximizes the functions that they have, maximizes the ability that they have. This amendment was proposed to us by OANHSS.

**The Vice-Chair:** Is there any further debate?

**Ms. Smith:** We will be dealing with the notion of restorative care in motions 26 and 67 that the government has put forward. As well, I take some exception to talking about the “remaining” strengths and abilities. We want to maximize “the” strengths and abilities, not what remains. So we will be dealing with this in our government motions, and I think our definition of “restorative care” set out in motion 67, which will amend subsection 8(1), is broader and more inclusive.

**The Vice-Chair:** Any further debate? None? All in favour of NDP motion number 13? Opposed? The motion is lost.

We move to PC motion number 14.

**Mrs. Witmer:** I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘volunteer’ means a person who offers service of his or her own free will without an expectation of gain, which service could be direct or indirect service to residents, but does not include family or others who are visiting or providing one-on-one care only to the person’s family member or personal friend who is a resident in the home;”

Certainly when OANHSS appeared before us, they did believe that without this definition, family members may be included and thus subject to criminal reference checks and other extraordinary provisions. So this definition was supported.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** In government motion number 9, we included a revised definition of “volunteer” which delineated volunteers as being those who are part of an organized volunteer program pursuant to section 15 and who do not receive a wage or salary for the services or work provided for in the program, which we think is a clearer definition. It’s cleaner. It’s those who are part of a volunteer program. So we think this motion is unnecessary.

**Ms. Martel:** I’d just point out, because I have a similar motion to Mrs. Witmer’s, that I’m not clear what an “organized volunteer program” is. I don’t know what that’s going to be defined to be, and I think that’s quite



limiting in terms of having people come into the home to aid or assist the home in a number of ways in the provision of care. I think the definition that both Mrs. Witmer and I put forward gives more flexibility to the home to allow people in and to allow people who are not direct family members to do things. I think the motion that has been put forward now is broader and actually will serve us better.

**The Vice-Chair:** Any further debate? None? All in favour of PC motion number 14? Opposed? The motion is lost.

We move to motion number 15 by the NDP.

**Ms. Martel:** This motion is similar to the one that was just put by Mrs. Witmer, and given that the government voted it down, I will withdraw it.

**The Vice-Chair:** Ms. Martel has withdrawn motion number 15.

We move to motion number 16 by the government.

**Ms. Smith:** I move that the definition of "secure unit" in subsection 2(1) of the bill be struck out and the following substituted:

"'secure unit' means an area within a long-term care home that is designated as a secure unit by or in accordance with the regulations; ('unite de sécurité')"

1000

**The Vice-Chair:** Any further debate? All in favour of government motion number 16? Opposed? None. Carried.

We move to motion number 17 by the NDP.

**Ms. Martel:** I have a different definition for "secure unit."

I move that the definition of "secure unit" in subsection 2(1) of the bill be struck out and the following substituted:

"'secure unit' means a part of the long-term care home where residents,

"(a) are protected from leaving due to risks associated with their diagnosis or behaviours, or both, and

"(b) are supported to achieve the highest level of functioning, freedom and choices possible through living in an enabling environment;"

This definition was proposed by OANHSS.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** I believe that this definition is more indicative of a specialized unit, and we refer to those in 43(1) and 30(4), (5) and (6). Our definition of "secure unit" that we just passed is more appropriate for what we're dealing with in the legislation.

**The Vice-Chair:** Any further debate? None? Now we'll put NDP motion number 17 to a vote. All in favour? Opposed? It's lost.

We move to NDP motion 18.

**Ms. Martel:** I move that the definition of "spouse" in subsection 2(1) of the bill be amended by adding "including a same-sex relationship" at the end.

This was proposed to us by OANHSS.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** I believe it would be inappropriate to make the amendment that has been suggested, as the

definition as it's set out in our legislation is the definition that is now used in all Ontario statutes, and to differentiate would put into question the other Ontario statutes that now include this definition of "spouse."

**The Vice-Chair:** Any further debate? None? All in favour of NDP motion number 18? Opposed? The motion is lost.

We will now move to government motion number 19.

**Ms. Smith:** I move that subsection 2(2) of the bill be struck out and the following substituted:

"Controlling interest

"(2) Without limiting the meaning of controlling interest, a person shall be deemed to have a controlling interest in a licensee if the person, either alone or with one or more associates, directly or indirectly,

"(a) owns or controls, beneficially or otherwise, with respect to a licensee that is a corporation,

"(i) 10 per cent or more of the issued and outstanding equity shares, and

"(ii) voting rights sufficient, if exercised, to direct the management and policies of the licensee; or

"(b) has the direct or indirect right or ability, beneficially or otherwise, to direct the management and policies of a licensee that is not a corporation.

"Same

"(2.1) Without restricting the generality of subsection (2), a person shall be deemed to have a controlling interest in a licensee if that person, either alone or with one or more associates, has a controlling interest in a person who has a controlling interest in a licensee, and so on."

**The Chair (Mr. Ernie Parsons):** Discussion?

**Ms. Smith:** This will enable us to address some issues that have been raised around who has actual control of an entity that has control over a long-term-care home.

**The Chair:** Any other discussion? We'll call the vote. Those in favour? Opposed? It is carried.

We move next to PC motion number 20.

**Mrs. Witmer:** I move that section 2 of the bill be amended by adding the following subsection:

"'Staff'

"(5) The definition of the term 'staff' in subsection (1) does not change the contractual relationship between the licensee and an independent contractor or impact requirements concerning income tax, workplace safety and insurance, or employer health tax."

**The Chair:** Do you wish to speak to this?

**Mrs. Witmer:** Yes. It speaks to the need to ensure that "staff," in relation to a long-term-care home, means persons who work at the home as employees of the licensee pursuant to a contract or agreement with the licensee, or pursuant to a contract or agreement between the licensee and an employment agency or other third party.

**The Chair:** Any other discussion?

**Ms. Smith:** I would just note that in motion 326 we have the regulatory power to exempt certain classes of staff from certain regulations. This will give us more

flexibility and allow us to in any way address any concerns that are raised through income tax rulings or others.

**The Chair:** Any other discussion? I would ask for those in favour. Opposed? The motion is lost.

Government motion number 21. Parliamentary assistant.

**Ms. Smith:** Thank you. Welcome, Chair. Happy to have you here.

**The Chair:** I left Belleville at 6 o'clock.

**Ms. Smith:** I move that section 2 of the bill be amended by adding the following subsection:

"Meaning of 'explain'

"(5) A rights adviser or other person whom this act requires to explain a matter directly to a resident or an applicant for admission to a long-term care home satisfies that requirement by explaining the matter to the best of his or her ability and in a manner that addresses the special needs of the person receiving the explanation, whether that person understands it or not."

**The Chair:** Do you wish to speak to the motion?

**Ms. Smith:** Adding this definition clarifies the role of the rights adviser.

**The Chair:** Any other discussion? Those in favour? Opposed? The motion is carried.

That concludes section 2, so I will now ask the question. Shall section 2, as amended, carry? In favour? Opposed? Carried.

That moves us to PC motion number 22.

**Mrs. Witmer:** I move that the portion of subsection 3(1) of the bill before clause (a) be amended by adding, "subject to the safety requirements and rights of all residents" at the end.

Again, this was an issue that was drawn to our attention by OANHSS. They indicated that there are situations where homes are faced with situations in which a resident or a family member insists on a right that may infringe on or violate the rights of others as described in part one of this submission. For example, the bill of rights has been interpreted to mean that a resident family member has the right to visit in the location of choice in the long-term-care home regardless of the risk it may present to others. Therefore, I do agree it is important for all residents and all family members to know that they do have an obligation. With rights go responsibilities and obligations, and they have a responsibility to contribute to a safe, respectful environment for everyone who is living in the long-term-care home. It is important that, throughout this act, we balance the rights of individuals with the need to also protect other people.

**The Chair:** Any other discussion? Parliamentary assistant.

**Ms. Smith:** We know that it's important to protect the concept that the bill of rights is about the individual residents. We do recognize that there were concerns raised, and through government motion 357 we will be addressing that by including a provision in the preamble to address mutual respect. I did raise that with a couple of the presenters who did raise the concern, and they felt

that would give them some ability to address the concerns they have raised.

**Ms. Martel:** Chair, can I ask a question on this? I have a similar motion to Mrs. Witmer's that comes under number 37, which says very clearly that the bill of rights is to be interpreted with a similar principle that she's outlining.

I guess I'm just not clear why we would be putting that in the preamble rather than in the section that directly speaks to rights and residents' rights, so if I could just get some clarification from the parliamentary assistant.

**Ms. Smith:** Sure. The bill of rights—we will amend it, but the general bill of rights has existed since 1993, and it's important that we ensure that the individual rights of residents are protected. By starting to include notions of collective rights within the bill of rights, it impacts on the ability of an individual to assert their right under the bill of rights, so we feel that mutual respect in the preamble allows for the homes to have something to turn to, should they need to address a concern around a collective right versus bill of rights situation in a home.

**Ms. Martel:** Can I ask one question, just because I'm trying to flip through to find yours. In the change that you propose to the preamble, does it speak very directly to the residents' bill of rights then, that the collective has to be balanced against the individual? I just want to give you the number, Monique. I can try to flip to it.

**Ms. Smith:** It's 357.

1010

**Ms. Martel:** Thanks.

**Ms. Smith:** Just for clarity, we will be proposing "strongly support collaboration and mutual respect amongst residents, their families and friends." We address the issue by addressing not only the residents but their family and friends, which I think goes some way to addressing the concern that has been raised about individual versus collective rights.

**Ms. Martel:** Could I just say one other thing? Perhaps in that context, then, the parliamentary assistant might consider something beyond collaboration that speaks to either safety in that particular amendment of 357—because I see collaboration and mutual respect as a little bit different from ensuring someone's safety or the safety of the collective.

**Ms. Smith:** We'll leave that till 357.

**Ms. Martel:** Sure, thanks.

**Mrs. Witmer:** Yes, I would certainly agree. I am obviously pleased to see the change in the preamble, but the reality is, I don't think that that preamble, which I'm just looking at now, adequately addresses the concerns that have been brought to our attention that sometimes homes are faced with situations in which the individual or the family is going to insist on a right simply because we have here a resident bill of rights. Yet, in doing so, their insistence will mean that it could violate the right or safety of other individuals. So I would hope, if the government is going to reject this motion, which it appears they will, that they more adequately address this concern in 357.



**The Chair:** No other discussion? Those in favour of the motion? Opposed? It is lost.

PC motion 23.

**Mrs. Witmer:** I'm going to withdraw that at this time since we are going to be dealing with that.

**The Chair:** That brings us to government motion 24. Parliamentary assistant.

**Ms. Smith:** I move that subparagraph 11 ii of subsection 3(1) of the bill be amended by striking out "treatment or care" and substituting "treatment, care or services."

**The Chair:** Does anybody wish to speak to it? Those in favour? Opposed? Carried.

Moving us to PC motion 25. Mrs. Witmer.

**Mrs. Witmer:** I move that paragraph 12 of subsection 3(1) of the bill be struck out and the following substituted:

"12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible."

I think the issue here is the introduction of the undefined term "restorative care services." What does it mean? If we take a look at the way in which resident right number 12 is stated, it presupposes the existence of a divine set of restorative care services to which a resident has a right. This right sets up an entitlement to a core of restorative care services which are currently not defined, nor are they funded, nor are they provided in long-term-care homes. It is rather disingenuous of the government to introduce new program elements through resident entitlements without some funding, which is not being provided. It certainly could lead to some disappointment.

**The Chair:** Any discussion? Ms. Smith.

**Ms. Smith:** We're all getting along so well. I just point out that motion 67 deals with addressing some of Ms. Witmer's concerns around the definition of "restorative care." Her motion 25 is quite similar to our 26, so we'd be willing to live with hers.

**The Chair:** Any other discussion? I'm going to call the vote. Those in favour? That's carried.

**Ms. Smith:** Chair, I withdraw motion 26.

**The Chair:** Okay. NDP motion number 27.

**Ms. Martel:** I move that paragraph 13 of subsection 3(1) of the bill be struck out and the following substituted:

"13. Every resident has the right not to be restrained, by either physical or chemical restraints, except in the limited circumstances provided for under this act and subject to the requirements provided for under this act."

We heard some concerns about the use of chemical restraints in terms of medication and potential over-medication of residents and that it should also be a right to not find oneself in this position. This was proposed to us specifically by SEIU. There were others who talked about physical and chemical restraints as well.

**The Chair:** Other discussion?

**Ms. Smith:** Actually, it's not broad enough because it doesn't include environmental restraints, and we think that chemical restraints are dealt with in sections 34 and 28(4) and 87(2) and 27. So we would be opposing this amendment.

**The Chair:** Any other discussion? I'll call the vote. Those in favour? Opposed? The motion is lost.

PC motion number 28.

**Mrs. Witmer:** I move that paragraph 14 of subsection 3(1) of the bill be struck out and the following substituted:

"14. Subject to the safety of the resident and the rights and safety of other residents, every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference."

Again, this was a concern that was raised by OANHSS. They pointed out to us that long-term-care homes do have the dual responsibility to respect and promote individual rights but at the same time protect the safety of the entire long-term-care community. So that potentially does create some conflicting obligations, and these obligations could create a little bit of hardship for the home. A resident could be abused behind closed doors and the home held responsible even though the home could not restrict visitors it suspects of abusing a resident from meeting with that resident in private if the resident allows those persons to visit. So at the same time section 17 places a duty to "protect residents from abuse by anyone." They were looking for some definition that would protect the homes in this type of a situation.

**The Chair:** Parliamentary assistant.

**Ms. Smith:** We do believe that the duty to protect under section 17 does go far enough to protect them. As well, we've got in our motion 357 the mutual respect provision in the preamble that we will be bringing forward. I have heard your concerns around safety and we will try to address that as well.

I would note, though, that in the discussions at the homes that we've had, they usually try to resolve these issues on a case-by-case basis. While we have heard that they want some recognition of mutual respect or living together, I don't think it's appropriate to put it in this section.

**The Chair:** Shall I call the vote? Those in favour of the motion? Opposed? The motion is lost.

PC motion 29.

**Mrs. Witmer:** I move that paragraph 15 of subsection 3(1) of the bill be amended by adding "unless this is impossible because of the restrictions resulting from the outbreak of an infectious disease" at the end.

This was an argument put forward by some of the long-term-care homes and the association. It is the duty of the local medical officer of health to declare an outbreak and to provide directives regarding required infection control measures. During an outbreak, restrictions are commonly placed on visiting as part of the infection control measures and these restrictions obviously vary by public health unit.

**The Chair:** Parliamentary assistant.

**Ms. Smith:** We appreciate your raising this concern. We've discussed it with the medical officer of health and the infectious disease branch at public health, and they advise us that visitation restrictions of the medical officer of health during outbreaks are flexible and compassionate, as is reflected in the provincial guideline A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, October 2004. They don't recommend complete closure of visitation as it may cause emotional hardship to residents and relatives. So there is some flexibility to allow for visitation during an outbreak. I think that providing this in the legislation is actually heavy-handed and that we should allow for the medical officer of health to make their determinations in their guidelines.

1020

**The Chair:** Shall I call the vote? Those in favour of the motion? Opposed? The motion is lost.

Motion 30. Ms. Witmer?

**Mrs. Witmer:** Again, this probably will be lost, but I move that paragraph 26 of subsection 3(1) of the bill be amended by adding "unless the physical setting makes this impossible" at the end.

**Ms. Smith:** Oh, so defeatist, Ms. Witmer. Actually, it's the same as our recommendation, motion 31, so we support you in this.

**Mrs. Witmer:** You know what? You're right.

**Ms. Smith:** There you go. Happy day.

**The Chair:** That's a great line to use, you know.

**Mrs. Witmer:** I know.

**The Chair:** Okay. There's no further debate. I will call the vote. Those in favour of the motion? Those opposed? It is carried.

Government motion 31.

**Ms. Smith:** Since Ms. Witmer did such a fabulous job on motion 30, we will be withdrawing 31.

**The Chair:** We're on a roll. Government motion 32.

**Ms. Smith:** I move that subsection 3(1) of the bill be amended by adding the following paragraph:

"27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home."

**The Chair:** Do you wish to speak to it?

**Ms. Smith:** Sure. We did hear some concern from some advocate groups that residents were feeling that they wanted the support of a friend or a family member or some kind of adviser when they were meeting with the home, so we thought that it was important to include that right in this legislation.

**The Chair:** Any other debate? I will call the vote. Those in favour of the motion? Opposed? It is carried.

That brings us to PC motion 33. Ms. Witmer.

**Mrs. Witmer:** Do you think the government's going to agree with us on this one?

**Ms. Martel:** I have a similar motion.

**Mrs. Witmer:** I know. Anyway, religious freedom. I move that section 3 of the bill be amended by adding the following subsection:

"Religious freedom

"(2.1) Nothing in the residents' bill of rights shall unjustifiably, as determined under section 1 of the Canadian Charter of Rights and Freedoms, require a licensee that is a religious organization or sponsored by a religious organization to provide a service that is contrary to the religious teachings of the organization."

This wording, by the way, is actually similar to the provisions in sections 26 and 28 of the Local Health System Integration Act. I think we need to remember that there are many people in the province of Ontario who are drawn to faith-based homes precisely because of their religious character, so I think it is important that we include in here this subsection to protect the religious freedom of faith-based homes.

**Ms. Martel:** I'm in support of Ms. Witmer because I have a similar motion next in motion 34. It was a while ago that I dealt with Bill 36, but my recollection is that the addition of those particular amendments were essentially to protect Catholic-based hospitals. That point had been made clear to us during presentations during the course of public hearings, so we did accept amendments at that time that would protect the integrity or the religious background/religious history of particularly Catholic hospitals, whether they had been started in many cases by orders of sisters, etc. I'm not sure why, if we did it with respect to hospitals, we wouldn't be doing exactly the same thing with respect to long-term-care homes.

**Ms. Smith:** We'll be opposing this amendment. It would provide the licensee with an unusual constitutional protection which is ordinarily only afforded to individuals. While I recognize that it was discussed with respect to Bill 36—that's a different entity—the hospitals had far different concerns than long-term-care homes have with respect to their religious rights. These protections would override the individual rights and, in fact, the resident would have to try and commence an action against a home in order to enforce them. So we'll be opposing this, as we feel it's not necessary in the context of long-term-care homes.

As well, I would note that we only heard from one presenter on this, a law firm, which made it clear that they didn't represent any particular home at the hearing. In fact, I believe only one stakeholder even made reference to it. While we did hear from a number of religious-based homes, most of them did not raise it.

**The Chair:** If there's no other discussion, I will call the vote. Those in favour of the amendment? Opposed? It is lost.

Bringing us to NDP motion 34, Ms. Martel.

**Ms. Martel:** This motion is the same as the one that had been presented by Ms. Witmer and was voted down by the government, so I will withdraw it.

**The Chair:** PC motion 35, Ms. Witmer.

**Mrs. Witmer:** I move that subsection 3(3) of the bill be struck out and the following substituted:



“Enforcement by resident

“(3) A resident may enforce the residents’ bill of rights against the licensee and the crown as though the resident and the licensee and the crown had entered into a contract under which the licensee and the crown had agreed to fully respect and promote to the best of their abilities all of the rights set out in the residents’ bill of rights.”

I think in a case where you have mutual responsibilities in a publicly funded program such as long-term care, where all of the revenues are determined by the government, it is not appropriate to have the bill of rights enforceable against only the licensee. There is a need to also include the crown—in this case, that would be the ministry—whose funding and whose legislation we’re debating here and who puts in place the regulations and policies that clearly affect the operator’s ability to meet rights. So that’s why I have substituted the current wording.

**Ms. Smith:** The bill of rights exists in the home and it is the provider that is providing services to the resident, not the crown, so it would be inappropriate to introduce the crown into this section.

**The Chair:** I’m going to call the vote. Those in favour? Opposed? The motion is lost.

NDP motion 36. Ms. Martel.

**Ms. Martel:** I move that section 3 of the bill be amended by adding the following subsection:

“Enforcement by others

“(3.1) If a resident is not capable of enforcing his or her rights under subsection (3), a family member or substitute decision-maker of the resident may do so on the resident’s behalf.”

This was part of the brief that was given to us by the Registered Nurses’ Association of Ontario. We think it speaks to the need to ensure that while there is a bill of rights, if for some reason you are incapable of enforcing it and it needs to be enforced, then your substitute decision-maker or family member can do so on your behalf when the resident is not capable of doing that themselves.

**Ms. Smith:** It is the residents’ bill of rights. I believe that if a resident is incapable, their substitute decision-maker would already be in the place of the resident and could enforce them. It would be inappropriate for a family member who wasn’t a substitute decision-maker to have the right to enforce it, because it is a residents’ bill of rights. So I’ll be opposing this amendment.

**Ms. Martel:** A quick question: If I took out “family member,” would you agree to it?

**Ms. Smith:** I believe it would be redundant because a substitute decision-maker would already stand in the place of a resident if they were found to be incapable.

**Ms. Martel:** Just for clarification on that, where is that guarantee provided? Is it provided as a result of someone becoming a substitute decision-maker?

**Ms. Smith:** Under the Substitute Decisions Act, yes, the substitute decision-maker would stand in the place of

a resident if they were found to be incapable. That’s the rule.

**Ms. Martel:** So from your perspective, there is not a requirement to make sure that’s clear with respect to these particular sets of rights.

**Ms. Smith:** My legal counsel is saying no.

1030

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? It’s lost.

NDP motion 37. Ms. Martel.

**Ms. Martel:** I move that section 3 of the bill be amended by adding the following subsection:

“Rights of others”—Chair, this is similar to the motion that was moved by Ms. Witmer earlier on. We’ve had a bit of a discussion about this, and I’m trusting that the parliamentary assistant and the legal staff and others are going to have another look at motion 357 to see what else can be added in addition to support, collaboration and mutual respect that will speak to the issue about safety. So, based on that discussion in an earlier conversation, I will withdraw this.

**The Chair:** Okay. PC motion 38?

**Mrs. Witmer:** Ours is very similar to the NDP motion just discussed and, again, we have discussed this with the government. I also hope that they will take into consideration the need for individual rights not to impinge on the rights and safety of other residents. I withdraw it.

**The Chair:** Okay. Thank you.

PC motion 39.

**Mrs. Witmer:** I move that section 3 of the bill be amended by adding the following subsection:

“Resident responsibilities

“(5) Every resident of a long-term care home has the following responsibilities:

“1. To collaborate with the care team of the home in developing and carrying out agreed-upon plans of care.

“2. To provide members of the care team with complete information about his or her health and communicate wants and needs as they arise.

“3. Make known his or her understanding of their plan of care.

“4. To express complaints or problems regarding his or her care to the care team.

“5. To recognize there are limits to what medicine and the health care system can realistically achieve.

“6. To be aware of the home’s obligation to respect the individual rights of all residents.

“7. To show respect for other residents, their family members, volunteers and the staff of the home.

“8. To meet financial obligations.

“9. To abide by administrative and operational policies and procedures of the home.”

I think it’s important to note that several other jurisdictions, for example the United Kingdom and Scotland, have enshrined resident patient rights while at the same time also speaking to patient resident responsibilities. I think one of the things that is lacking in Bill 140 is, although it does focus on the residents’ rights, it does not focus on the fact that with rights, whether you’re in a

long-term-care home or anywhere else, you do have responsibilities. I think there is a need to recognize that there are limits to what health and medicine can realistically achieve, and I think it's important that people be made aware of the need for the balance between the rights and the responsibilities.

**The Chair:** Any discussion?

**Ms. Smith:** I have deep concerns about this amendment. This legislation is to regulate licensees, not our residents. It would remove residents' choice. Specifically with respect to some of the notions—not limiting my concerns to these, but I would highlight that carrying out an agreed plan of care would seem to indicate that no one could change their mind on what the plan of care could be; limiting the expression of complaints and problems to the care team would limit them from making complaints anywhere else; number 6 we have already dealt with on the collective versus individual rights; and we will be moving an amendment to deal with the bad debt question, which I think addresses some of the financial obligations.

I'm concerned that we would, in this case, be regulating residents, and that's not our intention with this legislation, so we'll be opposing this amendment.

**Mrs. Witmer:** I hope the government does make the appropriate changes. This whole issue of rights and responsibilities was brought to our attention by the Ontario Association of Residents' Councils when they, 25 years ago, had a publication called Residents' Rights and Responsibilities. They believe today, as they believed then, that rights also do involve responsibilities to others. The OMA did speak to this issue as well, and also the Ontario Long Term Care Association. So I hope that the government does make the appropriate changes.

**Ms. Smith:** While I have no doubt that the OLTCA would support these changes, I have serious concerns that the residents' councils would. While I recognize that they do recognize responsibilities, I don't think they'd be in agreement with this amendment.

**Mrs. Witmer:** I'm saying they wanted responsibilities addressed.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? The motion is lost.

We have now completed the amendments to section 3. Shall section 3, as amended, carry? Carried.

That brings us to PC motion number 40.

**Mrs. Witmer:** I move that subsection 4(1) of the bill be struck out and the following substituted:

"Mission statement

"(1) Every licensee shall ensure that there is a mission statement for each of the licensee's homes that is put into practice in the day-to-day operation of the long-term-care home."

The ministry has talked about moving into a stewardship role in the newly recognized Ministry of Health and Long-Term Care, but there doesn't seem to be any alignment with this philosophy. What we see within this act are sections that are certainly excessively prescriptive,

process-oriented, and that in some cases could even be considered inappropriate.

I do believe there is a need for change. I do believe that homes should have a mission statement. However, how this is created I don't think should be in legislation, and we heard that from a lot of the long-term-care homes. Again, there is full support for the mission statements, because I do think you need to anchor the organizational direction, but I think the details as to how you actualize that should be left to the individual homes.

**Ms. Smith:** I would argue that our requirement that every home set out its principles, purpose and philosophy directly related to that home would better get to the notion of every home having a mission statement. The provision that Mrs. Witmer is providing will only allow corporate mission statements. I don't believe that Leisureworld North Bay is in any way related to Leisureworld O'Connor. I want their mission statement to reflect my home in North Bay.

I would note that if you go onto the website of some of our homes and you look under "mission statement," they'll direct you to their corporate head office mission statement, which I don't think in any way reflects the values necessarily or the aspirations of the residents of any particular home. So our government will be voting against this motion.

**The Chair:** Any other debate? I'll call the vote. Those in favour of the motion? Opposed? That is lost.

PC motion number 41.

**Mrs. Witmer:** I would withdraw that motion, given the response.

**The Chair:** Thank you. That brings us to NDP motion 42.

**Ms. Martel:** This amendment is the same as the one that was just withdrawn by Mrs. Witmer. I will withdraw it as well, given the government has already voted a similar amendment down.

**The Chair:** That brings us to government motion 43.

**Ms. Smith:** I move that subsections 4(3) and (4) of the bill be struck out and the following substituted:

"Collaboration

"(3) The licensee shall ensure that the mission statement is developed, and revised as necessary, in collaboration with the residents' council and the family council, if any, and shall invite the staff of the long-term care home and volunteers to participate.

"Updating

"(4) At least once every five years after a mission statement is developed, the licensee shall consult with the residents' council and the family council, if any, as to whether revisions are required, and shall invite the staff of the long-term care home and volunteers to participate."

**The Chair:** Do you wish to speak to it?

**Ms. Smith:** Yes. We did hear, as Mrs. Witmer alluded to earlier, the concern around being too prescriptive. We wanted to ensure that staff and volunteers were invited to participate but were not in any way required. As well, with respect to revisions, we wanted to just determine



whether revisions were required, as opposed to enforcing revisions every five years.

**The Chair:** Any other discussion? I'll call the vote. Those in favour? Opposed? That is carried.

PC motion 44.

1040

**Mrs. Witmer:** Based on what has just happened, I would withdraw that motion.

**The Chair:** Government motion—sorry. I will now ask the question, having completed section 4: Shall section 4, as amended, carry? Carried.

Government motion 45. No—

**Interjection:** Slow down, Ernie.

**The Chair:** My brain is still in Belleville—having a very good time, by the way.

Shall section 5 carry? Carried.

Now we go to government motion 45.

**Ms. Smith:** I move that subsection 6(1) of the bill be amended by adding “written” after “is a” in the portion before clause (a).

This is just an oversight. We always intended to have written plans of care, so we just wanted to make that perfectly clear in this legislation through this amendment.

**The Chair:** Any discussion on this? Those in favour? Opposed? It is carried, bringing us to NDP motion 46.

**Ms. Martel:** I move that subsection 6(1) of the bill be struck out and the following substituted:

“Plan of care

“(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

“(a) the resident's assessed needs, desires and strengths;

“(b) the goals and the expected results of the care and service strategies;

“(c) the roles and responsibilities of staff, others, the resident and his or her family in care and service provision and contributing to the goals and expected results;

“(d) how the team will monitor whether the expected results are or can be achieved and what, if any, other level of health care organization might be more appropriate to meet the resident's health care needs and provide the required care.”

This was submitted to us by OANHSS. I think it's a broader and, frankly, more appropriate provision with respect to what should be included in the plan of care. It focuses on things that are important in terms of the roles and responsibilities of others to support that plan of care. I think it is important, if it is at all necessary and another health care institution or facility might be better able to provide for the needs, that that be dealt with, so I think this is a stronger provision with respect to what we expect to go into a written plan of care.

**Ms. Smith:** We have, through our previous amendment, included “written.” We feel that including the resident's desires is a bit difficult. And with respect to (c) and (d), while we have been accused of being very prescriptive in this legislation, I would say that (c) and (d) are incredibly prescriptive. Trying to set out the roles and

responsibilities of staff, the resident, and his or her family in service provision is incredibly onerous and prescriptive. I would question whether my going in and, I don't know, doing something special for my mom would in some way violate a plan of care if it wasn't listed there as being my role as a family member. As well, with respect to (d), it is again overly prescriptive and I have concerns about determining other levels of health care organizations that might be more appropriate in a plan of care. It seems to be a way of trying to discharge residents.

**Ms. Martel:** I don't see it as a way to discharge residents. If there are very specific concerns that the home can't meet the care needs, then I hope the home and others who are involved in the care of that resident can recognize that and can respond to that in the best interests of the resident himself or herself.

With respect to whether or not this is prescriptive, I would point out that it was proposed to us by OANHSS, so it wasn't something that I dreamed up all on my own. I think that, as I said, it's much broader in terms of outlining what are those things we expect homes to put into a plan of care on behalf of each and every one of their residents.

**The Chair:** Seeing no other hands, I will call the vote. Those in favour of the motion? Those opposed? The motion is lost.

Government motion 47.

**Ms. Smith:** I'm looking at this in the context of Mrs. Witmer's motion number 48, which I think is very similar.

I move that clause 6(1)(c) of the bill be amended by striking out “as to how and when to provide the care” at the end.

**The Chair:** Any clarification?

**Ms. Smith:** While we did hear that there was concern around the onerous nature of some provisions in the legislation, we felt that it was best left to give clear direction, and as to how and when is determined by the care team.

**Mrs. Witmer:** This is very similar to my motion 48, and I'll be supporting this.

**The Chair:** No further discussion? Those in favour of the motion? Opposed? It is carried.

You are withdrawing PC motion 48?

**Mrs. Witmer:** I'm going to be withdrawing that, since we've just passed that.

**The Chair:** That brings us to government motion 49.

**Ms. Smith:** I move that subsection 6(2) of the bill be struck out.

I move this because we've defined “care” in the definitions section through a previous motion.

**The Chair:** Any discussion? Those in favour? Opposed? Carried.

Government motion 50.

**Ms. Smith:** I move that subsection 6(4) of the bill be amended by striking out “personal support, dietary” and substituting “personal support, nutritional, dietary.”

**The Chair:** Do you wish to speak to it?

**Ms. Smith:** Yes. We were advised by the registered dietitians that the scope should include “nutritional” and “dietary.”

**The Chair:** Any discussion? Those in favour? Opposed? Carried.

PC motion 51.

**Mrs. Witmer:** I move that subsection 6(6) of the bill be struck out.

Again, this subsection speaks to who should be given the opportunity to participate fully in the development and implementation of the resident’s plan of care, and again, this does create some confusion, given that subsection 6(6) appears to override the hierarchy of decision-making as set out currently in the Health Care Consent Act. If it is the intent of subsection (6) to recognize the reality of the involvement of family members and other persons designated by the resident in care, this probably should be stated in policy, as opposed to law.

**Ms. Smith:** I find it shocking that Mrs. Witmer would be suggesting that we be developing a plan of care for a resident that didn’t include the resident or give persons designated by the resident’s substitute decision-maker an opportunity to participate in developing the plan of care. What we’re trying to do through this legislation is make sure that the plan of care is resident-focused, and we’re trying to ensure that our homes are the home of the resident. I can’t imagine that we wouldn’t want those loved ones or the substitute decision-maker or the resident themselves involved in the development of their initial plan of care. It shocks me, quite frankly, that we would be suggesting that we take out this kind of collaboration.

**Mrs. Witmer:** If you take a look at the Health Care Consent Act, the reality is that it already ensures that a resident may appoint a substitute decision-maker who must follow the resident’s expressed care wishes. So this in no way is going to eliminate anybody’s involvement, and that is certainly not the intent. But there is some confusion that has been introduced here, and we’re simply looking to eliminate that confusion.

**Ms. Smith:** I don’t think there’s any confusion. In fact, in certain circumstances where a substitute decision-maker may not be readily available, it is appropriate that another person designated by the resident or the substitute decision-maker be given the opportunity to participate. In a case where, for some reason that I can’t even begin to imagine, my mother would choose my brother as her substitute decision-maker and I was right there in town—

**The Chair:** A bad example.

**Ms. Smith:** —a bad example; exactly—then by removing this provision, I would be precluded if we were only going to go with the Health Care Consent Act or the Substitute Decisions Act as being the only guidelines for our homes.

**The Chair:** Any additional discussion?

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**Mrs. Witmer:** Again, it was not the intent. There currently is a hierarchy of decision-making that is set out

in the Health Care Consent Act. As currently written, this does appear to be in conflict with that. I think it’s important that we have clarity in our decision-making.

**Ms. Smith:** I don’t believe there’s any conflict. We’ll be opposing this motion.

**The Chair:** I’m going to call the vote. Those in favour of the motion? Opposed? The motion is lost.

That brings us to PC motion number 52.

**Mrs. Witmer:** In light of the discussion we’ve just had, I withdraw this motion.

**The Chair:** That brings us to NDP motion number 53.

**Ms. Martel:** I move that subsection 6(7) of the bill be struck out and the following substituted:

“Development of initial plan of care

“(7) When a resident is admitted to a long-term care home, the licensee shall complete an assessment of the resident’s needs and utilize the results of this assessment to guide the written plan of care. If the results of this assessment are in conflict with the assessment provided by the placement coordinator, the long-term care home shall immediately consult with the resident’s placement coordinator to determine whether the individual was assessed as presenting a high risk to other residents of the long-term care home, and such finding may be cause to void the individual’s admission to the long-term care home in which case the placement coordinator will proceed to find an alternate health care setting for this resident.”

Under the section as it appears in the bill, there already is an obligation on the licensee to do an assessment within the times provided in the regulation, so I have no concern that the licensee has a requirement to do this. My concern is what the results of the licensee’s assessment might be once they’ve had a chance to do that and if there is a conflict. We hope it doesn’t happen, but there may be the potential that not all of the information for some reason makes its way to the placement coordinator or, secondly, from the placement coordinator to the home. So if, after having done that assessment, the licensee determines that the individual would not be suitably placed in that particular home but requires other care—clearly from my perspective, this would be around issues of behaviour, around issues of aggression or violence—then the placement coordinator would have to find another placement for that particular individual.

My concern also is that there is from time to time—and this is an unfortunate reality—a situation where not all of the relevant information might be disclosed to the coordinator by, for example, a family member or a substitute decision-maker who has information that may be extremely relevant. If that information isn’t provided to the placement coordinator, then that coordinator is not in a position to pass that on. So at the time of the assessment, if it’s very clear that there is quite a discrepancy between what was provided and what seems to be the case with the resident once assessed, there should be some kind of mechanism that can be triggered so that a more appropriate placement can then be worked out with the coordinator in the home.



**The Chair:** Discussion?

**Ms. Smith:** We'll be opposing this amendment. We feel that the requirements for admission to a home, which now set out more fulsome assessments under subsection 41(4), will address some of Ms. Martel's concerns. As well, in motion 141, the government will be looking at ensuring that assessments are done within the preceding three months, and if there is a significant change in the person's condition, we reassess them. We are also concerned that this provision would allow for there to be conflicting paperwork for a home to try to discharge a resident. We have made substantial changes to the legislation that will allow for fulsome assessments and to ensure that we are properly assessing those who have particular behavioural needs before they are admitted to any given home.

**Ms. Martel:** I had one thing: If there is conflicting information, then that should be a cause for concern and it should also prompt some action. If it is clear as the licensee does the assessment that the information that came from the coordinator is not fulsome or is not correct and, as a result, the placement of the resident in a home where his or her needs can't be met is an issue of safety to him or her or to staff or to other residents, then I think we need to deal with that.

So I'm not so much worried about conflicting information; I'm worried that if there is conflicting information, there's probably a good reason for it and we need to get to the bottom of it. If that conflicting information clearly shows that it's not an appropriate placement in a long-term-care home, we need to be doing something about that. That's the concern that I have with respect to this section.

**The Chair:** Any other discussion? I'll call the vote. Those in favour? Opposed? The motion is lost, bringing us to NDP motion number 54.

**Ms. Martel:** I move that section 6 of the bill be amended by adding the following subsection:

"Ministry to incur costs

"(9) The ministry shall be responsible for any costs incurred by the licensee in complying with subsection (8)."

It's very clear that under this whole section, plan of care, there are duties and obligations that are placed on the licensee.

**The Chair:** Prior to discussion—

**Ms. Martel:** You're going to rule it out of order?

**The Chair:** —I'm going to rule it out of order. Standing order 56: "Any bill, resolution, motion or address, the passage of which would impose a tax or specifically direct the allocation of public funds, shall not be passed by the House unless recommended by a message from the Lieutenant Governor, and shall be proposed only by a minister of the crown."

It's a financial obligation for the allocation of public funds, and I must rule it out of order, bringing us to PC motion number 55.

**Mrs. Witmer:** I'm prepared to withdraw motion 55, since the government has introduced motion 56, which is quite similar.

**The Chair:** Government motion 56.

**Ms. Smith:** I appreciate that, Mrs. Witmer. I thought ours was just a little bit cleaner, but I was going to try to do some friendly amendments to yours. This is easier.

I move that paragraphs 1, 2 and 3 of subsection 6(10) of the bill be struck out and the following substituted:

"1. The provision of the care set out in the plan of care.

"2. The outcomes of the care set out in the plan of care.

"3. The effectiveness of the plan of care."

**The Chair:** Discussion?

**Ms. Smith:** Sorry, Chair. It's kind of self-evident. It makes it a bit clearer. It puts it in the appropriate order: the provision, the outcomes, the effectiveness. There was some concern raised by a number of stakeholders on the language that we were using in documenting how the effectiveness of the care set out in the plan of care will be evaluated. In fact, what we wanted to get at was documenting the effectiveness of the plan of care. This just clarifies all of that.

**The Chair:** Any other discussion? I will call the vote. Those in favour of the motion? Opposed? It is carried, bringing us to NDP motion number 57.

**Ms. Martel:** I move that subsections 6(10), (11) and (12) of the bill be struck out and the following substituted:

"Documentation

"(10) The licensee shall develop and maintain documentation and reassessment of resident care and plan of care in accordance with provincially approved common assessment and care planning systems to reflect each resident's individual care needs."

This was submitted by OANHSS. The point here is to recognize that residents will have individual care needs, but to ensure that how they appear in a home, are kept in a home, provided to the director or to anyone else who might have a reason to have them, that the way that is outlined and the expectations of how it will be outlined in document form are ones that should be commonly approved. So whether the ministry sets them and gives some direction to the home of what they're looking for in terms of how that's documented, I think that would make more sense so that there is some consistency across all homes as to how this information is written, set out and kept and recorded.

**The Chair:** Further discussion?

**Ms. Smith:** I believe that the provisions that we just adopted in motion 56 are clearer. I would also note that in 36(2)(b), we have reg-making authority to develop regulations "requiring and governing the assessment and classification of residents for the purpose of determining care requirements and other needs." So in the regulations, we do address the need for assessment and classification of residents, and I believe that addresses some of the concerns that Ms. Martel is raising here. I believe our previous amendment under motion 56 provides a clearer outline of what we want in subsection 6(10).

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**The Chair:** Any other discussion? I'll call the question. All those in favour of the motion? Opposed? The motion is lost.

Government motion 58: Ms. Smith.

**Ms. Smith:** I move that subsection 6(11) of the bill be amended by striking out "at least every three months" in the portion before clause (a) and substituting "at least every six months."

**Mrs. Witmer:** We have made an amendment to this section, but instead of changing the three months to the six months, we have suggested that the plan of care be reviewed and revised when there is a significant change in status, with no time definition.

The Ontario Medical Association did raise some practical questions regarding the documentation and evaluation of a plan of care as well as questioning the frequency of the assessment. I know this is a change, but they were still concerned about the practicality of frequently repeated documentation and the onerous administrative burden this was going to create and the need for them to spend more time on administrative tasks, and they felt that this additional administrative responsibility was going to take time away from real hands-on care for the residents. There was also concern expressed by many of the long-term-care homes.

**The Chair:** Other debate?

**Ms. Smith:** Yes. We have in fact seen to addressing some of the concerns around onerous paperwork by reducing it to every six months as opposed to three months. We do address a change in the residents' care needs in clause 6(11)(b). Many residents in our long-term-care homes, as you know, Chair, and as everyone around this table knows, suffer from many chronic conditions, and the average stay in a home is about two and a half years. We think it's important that every six months we revisit the plan of care. We don't think that's too onerous a requirement. So that's why we put together this proposal and we support the revision every six months.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? It is carried.

This brings us to PC motion number 59.

**Mrs. Witmer:** In light of the motion that has just been passed, as I say, they did move from a three- to six-month assessment and my motion referred to a significant change in status, so I would withdraw this now.

**The Chair:** That brings us to NDP motion number 60.

**Ms. Martel:** I move that section 6 of the bill be amended by adding the following subsection:

"Same

"(11.1) The review and revision required by subsection (11) shall be done in such a way that ensures the plan of care continues to cover all aspects of care as set out in subsection (4), and, at a minimum, shall be carried out by the attending physician and registered nurse responsible for the resident's care."

This was a suggestion made by OANHSS. The point of the matter is, more than anything else, to ensure that the assessment is complete and that it's done by regulated

health care personnel who would be in a very good position to note whether or not there were changes in medical conditions, declining medical conditions, that would require then a revision to the plan of care.

**Ms. Smith:** I believe that the concern about the reassessment being done by certain health care professionals is addressed by the fact that in subsection 6(12), where we talk about the reassessment, we refer to subsections (5) and (6) as applying to a reassessment. Subsection 6(5) is the integration of assessments and care, so it ensures that all staff and others involved in the different aspects of care collaborate. So it's the requirement for collaboration and involvement. Both of those sections—collaboration and involvement—apply to the reassessment. So I think that specifying in this amendment that the attending physician and registered nurse be the ones carrying out the reassessment is actually narrower than our requirement, which requires integration of everyone involved. So we will not be supporting this amendment, as we feel it's already addressed in subsections 6(11) and (12).

**Ms. Martel:** Just as a clarification, my amendment says "at a minimum." It doesn't say "at a maximum" or that it should only include the attending physician and registered nurse. But it does say that, as part of the group involved in the assessment, those two individuals, at a minimum, should be included. So I don't see that it's restrictive. I think that it sets out at least two of the partners who should be there along with anybody else who's involved in the plan of care.

**Ms. Smith:** I would just point out that it's redundant because through the reassessment it is required that "the licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other," so that would include everyone.

**The Chair:** I shall call the vote. Those in favour of the motion? Opposed? Motion is lost.

Shall section 6, as amended, carry? Carried.

Moving then to—

**Ms. Smith:** Section 6.1? Sorry.

**The Chair:** There's a new section, section 6.1. I move now to government motion 61.

**Ms. Smith:** I move that the bill be amended by adding the following section:

"Assessment only with consent

6.1 Nothing in this act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent."

This is a provision that's in the long-term-care act now. We believe that it provides more clarity for the licensees and the staff as well as residents and their substitute decision-makers with respect to consent in the plan of care.

**The Chair:** Discussion? I'll call the vote. Those in favour? Opposed? Carried.

That brings us to government motion 62.

**Ms. Smith:** I move that the French version of subsection 7(3) of the bill be amended by striking out



“assure la permanence dans le foyer à tout moment” and substituting “soit de service et présent au foyer en tout temps.”

**The Chair:** Discussion?

**Ms. Smith:** It's just a clarification and a correction in the translation.

**The Chair:** I call the vote. Those in favour? Opposed? Carried.

That brings us to NDP motion 63.

**Ms. Martel:** I move that subsection 7(4) of the bill be amended by striking out “except as provided for in the regulations.”

The Ontario Nurses' Association raised this with us in their submission. In this particular section we're talking about a licensee's requirement to have a registered nurse on duty 24/7, and that that registered nurse should not, when they are on duty as part of that 24/7, be considered as administration or a director, but be there to be providing hands-on care. If that is the case and if that is the intention, and it should be, then I don't know what circumstance would be acceptable to allow for something other than that in the regulations. As currently drafted, subsection 7(4) does just that. It sets out at the start that “During the hours that an administrator or director of nursing and personal care works ... he or she shall not be considered to be a registered nurse ...except as provided for in the regulations.” So you have to mean one or the other. If we're serious that we're going to have a registered nurse on duty providing hands-on care 24/7, then I don't know what circumstances or other provisions there should be that wouldn't allow for that. I think having a provision that would allow for that in regulations does just that.

**The Chair:** Ms. Smith.

**Ms. Smith:** Obviously, we are committed to this notion since we are the ones who brought in the regulation, but I would note that there are certain circumstances and situations in smaller and rural areas where we are having some difficulty in meeting the requirement. We want to be sensitive to that and we want to maintain the flexibility in order to address certain geographic or workforce realities, so that's why we've introduced the notion of a regulation-making ability.

**Ms. Martel:** If I might, Mr. Chair, then that begs the question, if a licensee, especially in a rural area, is not able to meet this particular requirement, is it because they are not receiving enough funding from the government in order to meet their requirement? I think that's probably a serious issue for many of the homes with respect to staffing at all levels, not just in rural areas either. So the only circumstance I can see where there would be a need to have this in regulation is because a particular home can't meet the requirement because of inadequate funding to hire the nurses needed to do that. I just think that if we're serious about this, that a nurse has to be there 24/7 and not doing administrative duties during that time, then this has to change and the funding has to be provided to allow that to happen.

1110

**Ms. Smith:** Oh, it was all going so well, Mr. Chair. I feel compelled to note for the committee that the government has invested over \$740 million into long-term care over the last three years. We've hired 4,800 new staff, including 1,100 new nurses. We have made substantial investments. We are committed to this. A provision, however, as Ms. Martel would know, coming from the north and from a somewhat remote area, although many would argue that Sudbury is the centre of the universe, especially those from Sudbury—we would note that there are rural areas that are having some struggles in finding RNs to cover, and we just want to have the ability to address those concerns.

**Ms. Martel:** I am compelled to note for the committee that the government promised \$6,000 of enhanced care for every resident in every long-term-care home, and we know that as of the last budget and in the fourth year of this government, the government has only managed to cough up \$2,000 of that \$6,000 for enhanced direct care. So I think if the government coughed up the remaining \$4,000 per resident annually that they promised, every home would be in a position not just to have the RNs that they require, but the PSWs, the health care aides, the support staff etc.

**Ms. Smith:** My colleagues have asked that I note that it's not just northern, but there are rural areas that are having trouble, just to keep everybody happy. Duly noted.

Call the question, Chair, unless Mrs. Witmer has something to add.

**The Chair:** I call the question. Those in favour?

**Ms. Martel:** Chair, can I have a recorded vote?

**The Chair:** Recorded vote.

**Ayes**

Martel.

**Nays**

Fonseca, Leal, Ramal, Rinaldi, Smith.

**The Chair:** The motion is lost.  
NDP motion 64.

**Ms. Martel:** This has to do with adequate funding by the government for long-term-care homes too, so I know you're going to rule it out of order.

**The Chair:** Yes. Do you wish to withdraw it?

**Ms. Martel:** Yes.

**The Chair:** It's withdrawn.  
NDP motion 65.

**Ms. Martel:** I move that the bill be amended by adding the following—

**The Chair:** Sorry. I'm too fast.

I will ask the question: Shall section 7, as amended, carry? Carried.

Now NDP motion 65. I apologize for that.

**Ms. Martel:** I move that the bill be amended by adding the following section:

“Minimum care

“7.1 Every licensee of a long-term care home shall ensure that each resident of the long-term care home receives a minimum of 3.5 hours of nursing and personal care each day from registered nurses, registered practical nurses, personal support workers and health care aides, of which a minimum of .68 hours must be provided by a registered nurse.”

If I can speak to that, this has been an ongoing concern that I have raised, beginning with the debate at second reading, and it certainly was an ongoing theme that we heard during the course of the public hearings. I just want to put on the record those groups who made comments with respect to having a minimum standard of 3.5 hours during their submissions or in their verbal presentations during the question-and-answer. They include CUPE, ONA, SEIU, RNAO, CARP, OFL, Family Council Network Four, Ontario Society (Coalition) of Senior Citizens' Organizations and Care Watch, Multiple Sclerosis Society of Canada—Ontario division, Alliance of Seniors, and CAW council, to name a few.

The reason that I have spoken about this extensively both on second reading and during the course of the public hearings is that I feel very strongly that when there is no minimum of care, the care of residents declines, and I continue to feel very strongly that that was evidenced during the report that was done by PricewaterhouseCoopers in 2001, after the standard of care of 2.25 hours that the NDP had in place had been cancelled by the Conservatives. I note that during a resolution that was put forward by the Liberals in 2001, Ms. McLeod and Mr. Gerretsen took a similar approach and made it very clear on the record that if there aren't standards, then the standard drops. The PricewaterhouseCoopers study commissioned by the Ministry of Health and paid for by them was clear evidence and proof of that.

Secondly, in the recommendations from the Casa Verde inquest, an inquest that looked into the deaths of two residents at the hands of another who was aggressive, recommendation 29 very clearly states that the Ministry of Health and Long-Term Care, in the interim of having an updated study such as the PricewaterhouseCoopers, should fund and set standards that would increase staffing levels on average to no less than 0.59 registered nurses' hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case index.

We have taken that recommendation, which was made some time ago, and upgraded it, because we know that the care levels of residents have increased, to reflect a proportion that is similar to the one outlined in the Casa Verde recommendation, or the recommendation by the coroner's jury. So the 0.68 would be an update as a percentage of that which appeared in the Casa Verde recommendation, which was 0.59.

As well, the amendment makes it very clear who is to be involved in the hands-on delivery of care and who

needs to be counted in that equation. We're very clear to say that has to be registered nurses, registered practical nurses, personal support workers and health care aides, and no other, including administrative staff or dietary staff etc. What we are very concerned with and focused on are those individuals who on a daily basis have an interaction with residents because they are providing them with care.

So, in conclusion, this matter of minimum standards of care and the need to have minimum standards of care I think was repeated again and again during the course of the public hearings. We all heard that, both from family councils and from workers themselves. The 3.5 reflects what is happening in a number of other provinces.

Finally, the division of who should be involved makes it very clear that it has to be those people who are providing hands-on care on a daily basis.

So I hope that people will accept this amendment.

**The Chair:** Discussion?

**Ms. Smith:** We won't be supporting this motion. We would direct committee members to motion number 85. For a number of reasons, this motion should not be included in the legislation. It would be ill-advised to include an actual number, 3.5, in legislation. As we have recognized, care needs change. The previous one was 2.25, so 3.5 in legislation would be very difficult to amend at some point in the future. We would note as well that including 0.68 for a registered nurse goes against what we heard from various presenters, including the SEIU representatives, who would not include registered nurses in their number at all, so it's interesting that that would be provided for by Ms. Martel, given that some of her followers do not support it.

I would just like to take the opportunity to advise the committee again that in his auditor's report of 2002, the auditor did note that the PricewaterhouseCoopers report which Ms. Martel referred to considered only the amount of care provided, not the quality of care. And according to the consultants, the study's limitations included the fact that data for many of the comparative jurisdictions were gathered from three to five years earlier than the Ontario data and that several of the jurisdictions were required to submit the data for funding purposes, which may influence data quality, therefore questioning the validity of the study.

I also note that the government has reported that we are at 2.86 hours of care; through the funding that we have contributed to the system and through the hiring that we've done, we are presently at 2.86. Ms. Martel noted that other jurisdictions are at 3.5, and I believe that is just false. We don't have any evidence that any jurisdiction in Canada has a minimum staffing standard or is meeting a minimum staffing standard of 3.5. I would note that in Alberta, the minimum standard is 1.9 and their target is 3.5: no evidence that they are meeting the target. New Brunswick has indicated that they are moving toward a minimum standard but have nothing in legislation. Saskatchewan's minimum standard, I believe, is 2.1, not 3.5. So I would just, for the record, indicate that there is



no jurisdiction in Canada that has a minimum legislated standard, and it would be inappropriate to include this provision in our legislation.

**The Chair:** Mrs. Witmer next.

**Mrs. Witmer:** I think on this particular issue there was general agreement that there was certainly a need for more personal care and services for the residents within the long-term-care homes. I do believe that if the government was going to live up to its obligation and promise of 2003 to provide each resident with an additional \$6,000 for care, that would go a long way to improving the level of care that was currently provided.

There were some very heartbreaking, heart-wrenching stories that we heard from staff in the long-term-care homes who just simply couldn't provide for the needs of residents. In fact, I left there just a little bit shaken when I heard about what was happening to some of the people and how their needs, for example, were not being appropriately addressed because there simply wasn't enough funding to provide for the support and care that was necessary.

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Having said that, I know that the government, when I look ahead, has put in some enabling wording under section 15 which could allow for some debate and discussion during regulation development. When we take a look at this particular issue, I do believe it more appropriately should be addressed in regulation. But I think we need to not look at it in a cookie-cutter approach manner, as saying "a minimum." I think we need to make sure that resident care funding is needs-based. I think that's what we need to keep in mind, the individual needs of all of the residents. That may be more or it may be less. The reality is, residents are not getting the level of care that they need, according to the presentations that were made to us, and we need to somehow remedy that situation.

**Ms. Martel:** Let me make some comments. I find it interesting that the Liberals have a much different perspective on the PricewaterhouseCoopers report in government than they did in opposition. In opposition, the results of PricewaterhouseCoopers in terms of Ontario residents in long-term-care homes being dead last in every category of care were used extensively by former Liberal leader Ms. McLeod and by Mr. Gerretsen, who is now a cabinet minister. So what was good in opposition does not appear to be good in government, and I find that a little bizarre.

Secondly, with respect to the government's assertion that right now the standard of care that we have is, by the government's estimation, 2.86 hours, frankly, I have trouble believing that number, because I think the government used, for this particular comparison, the paid hours rather than the worked hours in their calculation. We may get some clarification about that. But in using paid hours instead of worked hours, you would find that the calculation would be much less, because the use of worked hours is actually the provision of hands-on care. So I have some difficulty with the government's number of 2.86, because I don't think it's that high. We certainly

heard from any number of presenters, both CAW and SEIU, who had done work on trying to determine hands-on care in their own homes that in almost every case it was less than 2.25, which had been the standard in place in 1995.

Thirdly, with respect to number 85, which is the government's amendment on care and staffing standards, I would note very clearly that there is nothing in this provision that says there actually shall be a standard that is provided in the regulations. I'd just point to amendment number 85, which says that every licensee of a long-term-care home shall ensure that the home meets the staffing and care standards provided for in the regulations. Well, they may be provided for in the regulations and they may not, because there is nothing in amendment 85 that compels the government to actually develop the regulations that every licensee should have to abide by. So I have very significant concerns that this may be passed and we may never see that regulation. There certainly isn't a timeline set out and we certainly haven't seen a regulation since the government was elected, even though in the last election campaign the Liberals promised residents and their families very specifically that they would reinstate a minimum standard of care.

I also note that last week the minister, in terms of his conversations to the media, was having none of this standard of care, so I am very perplexed by the conversation on the road to Damascus. Frankly, I wonder how serious he is about actually implementing the regulation, given that the government hasn't done anything yet, in the fourth year, in this regard, and given his comments to the media last week, which would clearly indicate otherwise and clearly indicate that he was not interested in establishing any minimum standard.

Finally, with respect to SEIU, my recollection was that they were concerned that an RN acting in the capacity of a director of nursing be considered in part of the staffing standard. That probably should be clarified, because that was certainly my recollection, that when they talked about RNs, it was in the context of being a director, not in the position of providing hands-on care.

Finally, with respect to the 0.68 hours, that came directly from the Ontario Nurses' Association. We ran that amendment by a number of unions—CUPE, ONA, SEIU in particular—and nobody had any problem with it.

**The Chair:** Any other discussion?

**Ms. Smith:** I would just like to remind the committee and Mrs. Witmer, who I think has a little bit of amnesia, that it was her government that removed the minimum standards of 2.5, that removed the requirement for 24/7 RNs, that didn't have surprise inspections and that removed any minimum bathing standards. So I totally empathize with her point of view on some of the presentations we received, but let's not forget the legacy that you left behind.

With respect to Ms. Martel and her perspective, again, I think it's inappropriate to include this in statute. I think it should be in regulation, and that's what we have enabled ourselves to do through motion 85. I would remind

you that there were presentations—in fact, there was one presentation that didn't want to include RPNs. I believe they were members of the SEIU, front-line workers who said that RPNs just handed out drugs and that they in fact did no hands-on care, so if we were to limit it to hands-on care, in their view it was only health care aides. I actually believe there were two different presentations from front-line workers—I think they were in Sudbury—that were that prescriptive. We did hear from others who would include RPNs but not RNs. We heard from others who would include RNs but not the director of care. We heard from some who would include dietary aides who assist in feeding and others who wouldn't. There was no consensus, I would argue, from all of the presentations on what should be included, and therefore I think we need to do some work with the stakeholders in the sector on what should be included in a staffing and care standard.

As well, with respect to paid hours and worked hours, in my discussions with some of the organizations, paid hours is what they would accept, so I think that there is actually no consensus around paid hours or worked hours. You may want to go back and revisit that.

So I would suggest that our motion 85 provides the government with the ability to set those standards, to consult with the sector in order to determine what should be included in those standards.

Just as a final note, you were concerned about the minister's statements last week. The minister is very concerned about setting minimum standards, and you'll note that in section 85 we talk about staffing and care standards, not minimum standards.

**The Chair:** Mrs. Witmer?

**Mrs. Witmer:** Yes, I do need to respond to the parliamentary assistant. I am very proud of the legacy that our party has on long-term care. Our government did initiate the construction of 20,000 new beds after there was no construction for 10 years. We did provide \$1.2 billion. We also did set about to establish a renovation capital plan for the renewal of the D beds, which was going to be followed with a capital plan for the renewal of the C and B beds in order that we would eliminate three- and four-bed wards and make all homes wheelchair-accessible and also with washrooms adjacent and private dining room/living room spaces for smaller groups of residents. So I'm very proud of the track record that we have.

I would remind the parliamentary assistant that it was her government that made the commitment in 2003. It was one of the promises that have been broken thus far that each resident was going to be provided with an additional \$6,000 for personal care. Now, if that amount of money was actually being provided to residents—and, as I say, it was a Liberal promise—there would be improved staffing and there would be more care being provided. So I would simply encourage the government to live up to its promise and follow through.

**The Chair:** Ms. Martel?

**Ms. Martel:** A couple of other things.

I'm going to reinforce for the record that this particular amendment that we've put forward today was

given and shown to SEIU Local 1 before I put it in. They had no trouble either with the amount of hours that would be dedicated to registered nurses nor with the list of four health care professionals that would be provided in a standard of care. So on behalf of SEIU Local 1, I want to reinforce that.

**1130**

Secondly, with respect to who should be involved, it was the government that said it would reinstate the regulation that had the minimum standard in terms of care, 2.25 hours. If you look at that regulation that was implemented by the NDP in 1993, it included registered nurses, registered practical nurses and health care aides. It did not include PSWs because, I suspect, in 1993 that probably wasn't a category of staff in most homes in the province of Ontario. It's very clear that we, in the regulation, had outlined who would be included, and the government, when in opposition, said that it would reinstate that very standard, which did include those three categories. We have added PSWs because it's clear that since 1993, there has been an additional category of staff worker who provides direct hands-on care, and they should be included in a standard as well.

With respect to paid hours versus worked hours, I raised this because I continue to question the validity of the government's level of care that they say is now being provided, and that is 2.86. Frankly, if the government had used worked hours of homes, I can tell you that that standard would be much less. So the issue I have with the number that the government is using right now is, what was that based on—paid hours or worked hours?—because there would be a significant difference downward if what we were looking at was the actual number of hours worked by staff providing care, which is the criterion we should be looking at in terms of assessing the level of care that we are actually providing.

I think that's where I want to end, Chair. Thanks.

**The Chair:** I will call the question.

**Ms. Martel:** Recorded vote.

**Ayes**

Martel.

**Nays**

Fonseca, Ramal, Rinaldi, Smith.

**The Chair:** The motion is lost.

That brings us to NDP motion 66.

**Ms. Martel:** I move that the bill be amended by adding the following section:

"Specialized units

"7.2.(1) The ministry shall establish specialized units in long-term care homes for the care of residents who are prone to aggression, and set staffing standards for these units to ensure they are staffed sufficiently with the appropriately skilled regulated health care professionals who have training in managing these behaviours and that



there is enough staff to care for these residents so they cannot harm themselves or others.

**“Unregulated staff**

**“(2) Any unregulated staff assisting regulated health care professionals in these specialized units must first have received the training known as U-FIRST training.”**

This recommendation comes from two sources—one from the brief that we heard from Concerned Friends of Ontario Citizens in Care Facilities. The direct wording comes from the recommendation that was made in the Casa Verde inquest—I believe it's recommendation 18, although I can't find it quickly—from the members of the coroner's jury, who were extremely concerned that there has been a great deal of aggression and aggressive behaviour. It was focused on in Casa Verde because of two deaths, but during the course of the over 50 days when presentations and testimony were heard, there were certainly numerous other examples of other deaths and other serious incidents in homes.

What this does is respond to a recommendation from the coroner's jury that we have to recognize that there are going to be residents who come into homes who are prone to aggression, prone to violence, and need to be cared for in very specific ways with very specific training that does not put them at harm themselves or allow them to harm staff or, just as importantly, harm other residents. Not only should we have specialized staff to do that, but they have to be in a unit in sufficient enough numbers to ensure that appropriate care can be provided. I think all those things have to be done to respond to that important recommendation.

**The Chair:** Discussion?

**Ms. Smith:** Yes. I would note that under clause 178(2)(f), we do provide the ministry with the ability to establish special programs in the units. This would go some way to addressing Ms. Martel's concerns. As well, section 16 allows us to create programs. Under government motion 128, we will be addressing the admission into any created specialized units through the CCAC. We do have the ability to create specialized units. I don't believe we're in a position to do that in legislation at this time. They don't presently exist, and it would be too prescriptive to set out in detail in the legislation their creation.

With respect to unregulated staff, I would note that subsection 74(1) provides for training, and we do in fact deal with training dealing with dementia. I think it is inappropriate to outline U-FIRST training in legislation when that is a particular type of training—although well recognized and certainly well respected with respect to dementia—developed by the Alzheimer Society. It would be inappropriate to list that in legislation and not allow for some changes in the future.

**The Chair:** Any other debate? I will ask, then, shall section 7.2 carry? All those in favour? Opposed? It is lost.

We come now to motion number 67, which has been replaced with motion number 67R. Government motion number 67R, I believe, has been distributed.

**Ms. Smith:** Sorry, Chair, I don't have it. Thanks.

I move that subsection 8(1) of the bill be struck out and the following substituted:

**“Restorative care**

**“(1) Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that,**

**“(a) promotes and maximizes independence; and**

**“(b) where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee.”**

**The Chair:** Any debate?

**Ms. Smith:** I would just note that motions 67, 68 and 69 are all dealing with a similar issue. In our amendment, we have recognized that it's an interdisciplinary program and that it's actually not a restorative care program but a philosophy. We are looking at promoting and maximizing independence of our residents. We want to ensure that that includes looking at their assessed needs and providing them with therapy, including physiotherapy.

I would just note for clarity that the only difference between motion 67R and motion 67 was changing the words “and to the therapy services” to “and other therapy services.” It was a typo.

**The Chair:** Any other debate? I'll call the question. Those in favour?

**Ms. Smith:** Sorry, I think Mrs. Witmer may have had something to say.

**The Chair:** Sorry, Mrs. Witmer.

**Mrs. Witmer:** I guess what we need to be sure of here is, if there are expectations that this is going to be delivered, we also need to make sure the funding is going to be provided. We don't want to raise unrealistic expectations on the part of the residents and their families.

**The Chair:** I will call the question. Those in favour of the motion? Opposed? It is carried.

That moves us to NDP motion number 68.

**Ms. Martel:** Mr. Chair, based on the motion that was just passed, I will withdraw this one. But I will reiterate Mrs. Witmer's concern that the funding be available to provide the services the government references.

**The Chair:** That brings us to PC motion number 69.

**Mrs. Witmer:** I'll withdraw that and just add again that this is a new and unfunded program. It needs funding.

**The Chair:** That brings us to NDP motion number 70. Do you wish to read it before I declare it out of order?

**Ms. Martel:** Yes, I would Chair, thank you.

**“Sufficient funding**

**“(3) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met.”**

**The Chair:** I have to rule it out of order.

**Ms. Martel:** I understand.

**The Chair:** I will now ask the question. Shall section 8, as amended, carry? It is carried.

That brings us to government motion number 71.

**Ms. Smith:** I move that subsection 9(1) of the bill be amended by striking out "and assessed needs."

**The Chair:** Any clarification required, any discussion?

**Ms. Smith:** I would note that this is similar to motion 72. We heard loudly from some of our long-term-care home providers that they felt that this threshold that we were placing to meet the assessed needs was too much, too high. So we want to ensure that we are providing an organized program of recreational and social activities in the homes to meet the interests of our residents, obviously going some way to meet their needs. But setting a threshold of ensuring that we meet their needs is too high.

1140

**The Chair:** If there's no debate, I will call the question. Those in favour? Opposed? It is carried, bringing us to PC motion number 72.

**Mrs. Witmer:** I'll withdraw the motion. Our concern was around the new programming that was being required to meet the assessed needs of the residents and the lack of funding to provide that.

**The Chair:** Now we have NDP motion number 73.

**Ms. Martel:** I move that section 9 of the bill be amended by adding the following subsection:

"Sufficient funding

"(3) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met."

**The Chair:** As this is a money motion, it is out of order.

I will now ask the question. Shall section 9, as amended, carry? It is carried, bringing us to NDP motion number 74.

**Ms. Martel:** I move that section 10 of the bill be amended by adding the following subsection:

"Sufficient funding

"(3) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met."

**The Chair:** In order to be consistent, I must rule it out of order.

I will now ask the question. Shall section 10 carry? It is carried, bringing us now to PC motion number 75.

**Mrs. Witmer:** I move that section 11 of the bill be amended by striking out "to meet the medical needs of the residents."

That is similar to government motion 76. Basically, I think it speaks to what is required and doesn't go beyond.

**Ms. Smith:** We support this.

**The Chair:** If there's no other debate, I will call the vote. Those in favour of the motion? Opposed? It is carried.

**Ms. Smith:** I withdraw motion number 76.

**The Chair:** Motion number 76 is withdrawn, bringing us to NDP motion number 77.

**Ms. Martel:** I move that section 11 of the bill be amended by adding the following subsection:

"Sufficient funding

"(2) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met."

**The Chair:** The motion is out of order.

I will now ask the question. Shall section 11, as amended, carry? It is carried.

That brings us now to NDP motion number 78.

**Ms. Martel:** I move that section 12 of the bill be amended by adding the following subsection:

"Sufficient funding

"(3) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met."

**The Chair:** The motion is out of order.

I will ask the question. Shall section 12 carry? It is carried, bringing us now to NDP motion number 79.

**Ms. Martel:** I move that section 13 of the bill be amended by adding the following subsection:

"Sufficient funding

"(2) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met."

**The Chair:** The motion is out of order.

I will now call the question. Shall section 13 carry? It is carried, bringing us now to NDP motion number 80.

**Ms. Martel:** I move that section 14 of the bill be amended by adding the following subsection:

"Sufficient funding

"(3) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met."

**The Chair:** The motion is out of order.

I will now ask the question. Shall section 14 carry? It is carried, bringing us now to government motion number 81.

**Ms. Smith:** I note that 81 is somewhat similar to 84, which is Mrs. Witmer's motion, although we are moving to keep the first line of subsection (2).

I move that subsection 15(2) of the bill be struck out and the following substituted:

"To be included in program

"(2) The volunteer program must include measures to encourage and support the participation of volunteers as may be further provided for in the regulations."

We heard a great deal of concern around our listing of who had to be contacted. What we are trying to do in this legislation, in this particular section, is to encourage and support the participation of volunteers and to give homes some indication of where we expect them to go in encouraging or in recruiting volunteers. So we want to leave in the notion of the encouragement and support of the participation of volunteers, but we will be taking out the listing of who should be contacted.

**The Chair:** Any other discussion? We'll call the vote. Those in favour of the motion? Opposed? It's carried.

This brings us now to NDP motion 82.

**Ms. Martel:** I move that subsection 15(2) of the bill be struck out and the following substituted:

"Sufficient funding



“(2) The ministry shall ensure that sufficient funding is supplied to permit the requirements of this section to be met.”

**The Chair:** The motion is out of order. That will bring us to PC motion 83.

**Mrs. Witmer:** We’ve dealt with the issue of volunteers, so I would withdraw that motion.

**The Chair:** That is withdrawn.

PC motion 84.

**Mrs. Witmer:** I would withdraw that motion regarding volunteers, since the government has introduced an amendment. I would just mention at this point in time that I don’t think you can force community relations, and I hope that the volunteer program will be flexible, based on resident needs and community resources.

**The Chair:** Have you spoken to the motion that you’ve withdrawn?

**Mrs. Witmer:** I have.

**The Chair:** That was good.

Okay. I will now ask the question. Shall section 15, as amended, carry?

**Ms. Smith:** It carries.

**The Chair:** Thank you. It is carried.

We have a new section 15.1, government motion 85.

**Ms. Smith:** I move that the bill be amended by adding the following section:

“Staffing and care standards

“15.1(1) Every licensee of a long-term care home shall ensure that the home meets the staffing and care standards provided for in the regulations.”

**Mr. Jeff Leal (Peterborough):** Mr. Chair, can I have a recorded vote on this one when it comes up for a vote?

**The Chair:** Yes, certainly. Discussion?

**Ms. Smith:** I believe we’ve already had most of the discussion on this point. Certainly we did hear from a number of presenters. As I’ve indicated in our previous discussion—I really don’t think we have time to rehash the entire previous discussion, but there was some discussion about what should be included. I believe that we need some consultation on that. I also know that we heard from some PSWs who came before us and talked about their tasks, and not all of their time would be included in hands-on care. They talked about loading linen carts, cleaning equipment, putting away laundry, preparing meds, answering phone calls, those kinds of things.

We heard different numbers of hours of care that front-line workers felt they were providing. We heard about bath people as being someone else who should be included, whether or not they’re personal support workers or RPNs. We also heard from a variety of people who did not believe that RNs should be included. So we believe that our motion here is broad enough to allow for consultation on what should be included in a staffing and care standard and would allow us to bring that in under regulation.

**The Chair:** Ms. Martel.

**Ms. Martel:** I don’t intend to rehash the arguments I already made. I want to focus specifically on this

particular amendment and ask if the government is open to a friendly amendment. Right now it’s very clear that the licensee has some responsibility to ensure that the home meets staffing standards. There isn’t a similar responsibility to ensure that the regulation is actually drafted.

I would propose an amendment that would include “that shall be” between “standards” and “provided.” The new amendment would read as follows: “Every licensee of a long-term-care home shall ensure that the home meets the staffing and care standards that shall be provided for in the regulations.”

**The Chair:** We have an amendment to the amendment. Any discussion on it?

**Ms. Smith:** Can we get some direction from leg. counsel as to whether that’s an appropriate friendly amendment?

**Mr. Ralph Armstrong:** The office of the legislative counsel, in our role—as you know, we serve in several roles: advising the members, advising the government, advising the assembly—has always taken the position that it is inappropriate to require the government to make regulations. It goes against the philosophy of the Legislature in giving the allocating of power to the Lieutenant Governor in Council. It can create a situation in which, despite the best intentions at the time that a legislative provision is made, the reality of the situation prevents a regulation from being made in a timely fashion or being made at all and opens the possibility to judicial review actions, possibly, that are not in anybody’s interest but are based upon a perceived failure to proceed with the requirement, when in fact only the ordinary processes of government, including concerns by stakeholders, are being addressed in the regulation-making process.

I have been long-winded here. I apologize. I guess it all comes to what I said at the beginning. We’ve always advised against mandatory regulation provisions.

1150

**Ms. Martel:** So if the counsel says it’s inappropriate to make that friendly amendment, let me add two things, then, with respect to the government amendment: I looked elsewhere in the bill for the regulation-making process that the government was going to put forward, and it may be that you’re going to accept either my amendment or Ms. Witmer’s amendment that comes from the language of Bill 36, which includes very specific provisions for public consultation in regulations, sets out timelines etc. I didn’t see the government move that, although I’m assuming that one of those two is going to be accepted. Do you want to respond to that first?

**Ms. Smith:** Yes. I’m sorry; I thought that ours went over it last night. We were going to walk one in. It’s a variation on a theme. We haven’t received our amendment. It’s coming, I’m told. We said publicly last week that we would be seeking public consultation on the regulations. We have looked at the two motions that have been put forward and are bringing forward our own. By the end of lunch you will have that. It’s number 3-some-

thing, so I figured we'd be doing it tomorrow. I meant to have it to you this morning.

**Ms. Martel:** That's okay. Because we didn't have that conversation, I looked specifically for that because you had said that on the record. So I just assumed maybe you were having a conversation with Ms. Witmer and you were going to accept hers, which was going to be fine, because they're the same. So we will wait to see that.

The second point I do want to make on the record, though, is that in whatever sense I can urge the government to deal with this, I am asking you to do deal with this. I think that all of us heard during the course of the public hearings the desperate need there is to ensure that there are adequate staff in homes and that there are some standards attached to that so we can be sure that the money that goes to homes is going to that care. So, even though I can't move an amendment that says "shall be" to actually ensure that the government does that, I am urging you in the strongest terms to do that, and as soon as possible, based on what we heard during the course of the hearings.

**The Chair:** Ms. Martel, your amendment is in fact on the floor. Do you wish to withdraw it or to vote on it?

**Ms. Martel:** I'm going to withdraw it based on what legislative counsel has said to us, and I'm just speaking directly to the government's motion now.

**The Chair:** Ms. Witmer?

**Mrs. Witmer:** I would not be able to support this amendment here regarding staffing and care standards in that it speaks only to the licensee having to meet that and doesn't address the fact that what may be contained in the regulations would require additional funding, and there's no indication that the government is going to be providing that funding, so I don't know how we could achieve that.

I'm pleased to see that the government has put this enabling legislation, this amendment, in here but I do think we need to continue to keep in mind that staffing needs to be resident-based, and I hope that funding will also be considered.

**Ms. Smith:** I'm not at all surprised that Ms. Witmer is taking that position, given that she removed the standards before. We recognize that a minimum standard doesn't necessarily address all the needs, and that's why we've addressed it broadly as a staffing and care standard. I would just say to Ms. Martel, obviously our government did not bring motion 85 in lightly. There has been a lot of consideration made and we certainly heard from various stakeholders, so we will be moving forward as the motion indicates.

**Mr. Leal:** I requested a recorded vote, Chair.

**The Chair:** Yes. I will call the question. A recorded vote on government motion 85.

#### Ayes

Fonseca, Leal, Martel, Ramal, Rinaldi, Smith.

**The Chair:** Those opposed? The motion is carried.

Government motion 86.

**Ms. Smith:** I move that section 16 of the bill be struck out and the following substituted:

"Standards for programs and services

"16(1) Every licensee shall ensure that the programs required under sections 7 to 15, the services provided under those programs and anything else required under those sections comply with any standards or requirements, including outcome measures, provided for in the regulations.

"Matters included

"(2) Without restricting the generality of subsection (1), every licensee shall comply with the regulations made under clause 178(2)(f)."

With respect to the outcome measures, that's for consistency of drafting. It's considered the term that people refer to as opposed to just "outcomes."

With respect to clause 178(2)(f), we're requiring the licensees to provide or offer certain types of accommodations and services, and we just want to make sure that that's rolled into this section.

**Mr. Leal:** Can I get a recorded vote on this one?

*Interjection.*

**Ms. Martel:** Mr. Chair, can I just have a chance to flip over to 178?

**Ms. Smith:** That's a reg-making power.

**Ms. Martel:** Is that a new one?

**Ms. Smith:** No. Clause 178(2)(f) requires "licensees to provide or offer certain types of accommodation, care, services, programs and goods to residents, and governing the accommodation, care, services, programs and goods that must be provided or offered, including establishing standards or outcomes to be met."

**Ms. Martel:** That's the one that's further on. Sorry, Monique. I was flipping to 178. What's the number at the top of the amendment you're referring to?

**Ms. Smith:** That I'm talking about right now? I'm talking about motion 86.

**Ms. Martel:** So 178(2)(f) is an existing amendment in the bill. You're not changing that?

**Ms. Smith:** It's an existing provision in the bill.

**Ms. Martel:** Can you just give me one second, just so I can—

**Ms. Smith:** We're just cross-referencing 178(2)(f) into section 16.

**Ms. Martel:** And the reference again is to standards, that they'll be included in terms of the development in the regulations, what the standards look like. Am I correct about that?

**Ms. Smith:** Yes.

**The Chair:** Any other discussion? A recorded vote has been called for.

#### Ayes

Fonseca, Leal, Martel, Ramal, Rinaldi, Smith, Witmer.

**The Chair:** There being none opposed, the motion is carried.



I will now ask the question. Shall section 16, as amended, carry? It is carried.

That brings us to PC motion 87.

**Mrs. Witmer:** I move that section 17 of the bill be amended by striking out “by anyone.”

Obviously, you can't protect residents from abuse by anyone. It's not possible to ensure, for example, that a family member wouldn't abuse a resident. Sometimes there is financial abuse. And there is an obligation in the bill of rights to allow for privacy, so sometimes, if a resident chooses to meet with someone, it's difficult to prevent abuse from happening because they have the right to meet in privacy. So I think the current language is a bit of a recipe that could lead to failure. It would be difficult for anybody to meet that obligation. I think we have to be realistic and remove the words “by anyone.” Sometimes the resident would leave the long-term-care home as well, so again, how could you protect them from individuals they might meet?

**Ms. Smith:** In our motion 88, we address residents who are absent from the home. In this section, we're concerned that this amendment would water down the provisions related to the protection of residents. Obviously, our foremost concern is the protection of residents. I would note that we do not say that they shall ensure that no one is abused, which would be a higher standard that would be very difficult to meet, but we are saying that the home shall protect residents.

If there is a concern with respect to someone meeting privately, there is nothing to preclude the nurse, the RPN, the personal support worker from knocking on the door and entering to check on the resident, for whatever reason, which they would normally be doing in the course of their duties, which would allow them the opportunity to ensure that the resident is protected from any abuse.

We think it's important that we include “by anyone,” because if we don't, it's hard to foresee which individuals could have access. So we think the broader terminology is necessary, and we just highlight that the utmost thought in our mind is the duty to protect our residents.

**The Chair:** Any other discussion?

**Ms. Martel:** I don't disagree with the parliamentary assistant. The only thing that worries me is really around financial abuse. You've got all different kinds of family members meeting with the residents, sometimes with different agendas. If a family member insists that there be a private meeting and the resident goes along with that, I remain just a bit concerned about how you'll ever monitor that possibility. It's that form of abuse that I'm nervous about in terms of being able to monitor and manage, especially if people are meeting in private. There's a power relationship there that could be really difficult. I just raise that with you as a concern, and the ministry can think more about how they want to deal with that particular issue.

**Ms. Smith:** We have heard that concern, and obviously it's a difficult one to address. Certainly, we've heard from some residents' groups and resident advocacy

groups that feel we are being overly protective if we try to interfere in their relationship with their family. We all recognize there's a fine line there of trying to both protect the residents but also allow them their autonomy as individuals. But I don't believe that by excluding “by anyone,” we are in any way helping the situation of protection.

**The Chair:** I'm going to call the vote. Those in favour of the motion? Opposed? It is lost.

Members of the committee, if we do government motion 88, we will have completed section 17. So if we could do government 88 prior to lunch.

**Ms. Smith:** You give me such strength to get through this one since I didn't think we were ever going to end for lunch.

**The Chair:** The hungrier you are, the shorter the debate will be.

**Ms. Smith:** I move that section 17 of the bill be amended by adding the following subsection:

“If absent from the home

“(2) The duties in subsection (1) do not apply where the resident is absent from the home, unless the resident continues to receive care or services from the licensee, staff or volunteers of the home.”

Mr. Speaker—sorry, Mr. Chair. I was going to promote you right there, before lunch.

*Interjection.*

**Ms. Smith:** I believe this goes some way to address Mrs. Witmer's concern raised earlier and that we did hear about before the committee. We cannot protect our residents when they are off-site in the care of others, but we certainly do want to make sure that the licensees continue to be responsible if they are with the resident in some kind of activity situation. That's why we've brought this motion.

**The Chair:** Any discussion? Those in favour of the motion? Opposed? It is carried.

Shall section 17, as amended, carry? Carried.

Thank you. We are now recessed until 1 o'clock.

*The committee recessed from 1203 to 1303.*

**The Chair:** We are back in session. We are at PC motion 89.

**Mrs. Witmer:** I will withdraw that motion, since the government has a very similar motion in number 90.

**The Chair:** Thank you. That brings us to government motion 90.

**Ms. Smith:** Chair, I had confirmed to my colleagues that I would have government motion number 3-something on the amendments. Can I just hand that out quickly?

**The Chair:** Certainly.

**Ms. Smith:** Thank you. Sorry, Chair. I'd undertaken to have that by the end of lunch, so I wanted to get it to them.

Moving to motion 90, I move that subsection 18(3) of the bill be struck out and the following substituted:

“Communication of policy

“(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents

is communicated to all staff, residents and residents' substitute decision-makers."

**The Chair:** Any clarification?

**Ms. Smith:** Yes. There had been some concern that we were requiring the communication of the promotion of a zero tolerance abuse and neglect policy to a wide variety of people. We have determined that a number of the individuals listed in the original subsection (3) can be dealt with through the posting of that policy, so we have limited it to those who we feel really do require the policy: the staff, residents and substitute decision-makers.

**Mrs. Witmer:** The current wording was somewhat unrealistic as far as it being achievable. Really, it indicated that anybody, whether it was a delivery person, ambulance attendant or someone doing a repair, would be included. So this is certainly realistic and can be achieved.

**The Chair:** If there's no other discussion, I will call the vote. Those in favour? Opposed? It is carried.

I will now ask the question. Shall section 18, as amended, carry? It is carried.

There are no amendments to section 19. Shall section 19 carry?

**Ms. Smith:** What happened to motion 91?

**Mrs. Witmer:** Yes, what happened to the motion?

**The Chair:** Number 91? Well, it's too late. We snookered you on that one.

**Ms. Smith:** Unanimous consent to reopen 18 to allow the motion?

**The Chair:** I ask for unanimous consent to reopen section 18.

*Interjection.*

**The Chair:** Okay. PC motion 91.

**Mrs. Witmer:** I move that section 18 of the bill be amended by adding the following subsection:

"No reinstatement for abusers

(4) Despite the provisions of any collective agreement or the Labour Relations Act, 1995, where a staff person has been terminated by the licensee for abuse under the zero tolerance policy and there has been a finding of abuse, arbitrators and the Ontario Labour Relations Board shall have no jurisdiction to reinstate the employment of the staff person."

There was a concern expressed to us that in the case of someone being accused by another member of staff, they were afraid of the retaliation that could occur if that staff member was reinstated. Again, I think we need to ensure that someone who has been terminated for abuse does not come back and jeopardize resident safety.

**The Chair:** Any discussion?

**Ms. Smith:** We've done a review of case law and haven't found that to be the case. Our advice is that in certain situations, an arbitrator, given this high threshold, will not find abuse where there is some question so as to not find themselves falling under this provision. So we will not be supporting this provision.

**The Chair:** If there's no other discussion, I will call the vote. Those in favour? Those opposed? Carried.

I will again ask the question. Shall section 18, as amended, carry? Carried.

Government motion 92.

**Ms. Smith:** I move that subsection 20(2) of the bill be amended by striking out "who has forwarded" and substituting "who is required to forward."

This is just to clarify that someone who is required to forward must then provide the documentation. In this case, the way it was formally drafted, it would only be for those who actually had met the requirement and had forwarded, so we want to make sure we capture anybody who was supposed to have forwarded.

**The Chair:** Any discussion? Those in favour? Opposed? Carried.

Shall section 20, as amended, carry? It is carried.

Moving now to PC motion 93.

**Mrs. Witmer:** I move that section 21 of the bill be amended by adding the following subsection:

"Annual report

"(4) The director shall prepare an annual report from the reports received under subsection (2) as the basis of quality improvement and performance management activities by the ministry in relation to long-term-care homes, and for such other purposes that may be provided for in the regulations."

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**The Chair:** Do you wish to speak to it?

**Mrs. Witmer:** No. I think it's self-explanatory.

**Ms. Smith:** There's nothing precluding the ministry from doing this in policy, and I don't think it's appropriate to put it in the legislation. As it stands, the annual inspection and investigation of complaints reports are posted on a website, so they are readily available.

**The Chair:** I will call the vote. Those in favour of the motion? Those opposed? It is lost.

Shall section 21 carry? It is carried.

That moves us now to government motion 94.

**Ms. Smith:** I withdraw this motion.

**The Chair:** Thank you. That moves us to PC motion 95.

**Mrs. Witmer:** I move that subsection 22(3) of the bill be amended by striking out "and subsection (2) does not apply to residents."

In some respects, I think this contradicts the element of dignity that is set out in the fundamental principle. If you take a look at paragraph 6 of subsection 3(1), it clearly sets out the right of residents to "exercise the rights of a citizen," and in paragraph 17 of subsection 3(1), to "raise concerns or recommend changes in policies and services...." Given these enforceable rights, there is really no reason, then, to excuse residents from knowingly providing false information in a report related to section 22.

**The Chair:** Ms. Smith?

**Ms. Smith:** We'll address this in our motion 96, where we limit it to those residents who are incapable. Subsection (2) does not apply to residents who are incapable, so we are restricting it to only those who are incapable. That'll be our motion.



**Mrs. Witmer:** We received a significant amount of input on this issue from homes, and also from the Ontario Medical Association, which indicated that they believe it to be absurd that a resident of a long-term-care home should be enabled, by law, to make knowingly false statements or reports to the director about staff with impunity and without any responsibility to complain with integrity and truthfulness. They recognize that residents need to feel comfortable about bringing forward concerns and complaints, but this actually could have reverse consequences.

The RBJ Schlegel Research Institute for Aging suggests that subsection 22(3) almost excludes residents themselves from being truthful. They say that this could perhaps have the consequence of discouraging researchers from attempting to advance the knowledge base for long-term care through home-level research work. So there was some concern expressed about this.

**Ms. Martel:** Can I just ask a question in this regard? I appreciate that the government is trying to limit it to people who are incapable, and what I'm wondering is whether there is a definition that is to be used only for this. The last thing you want is for the director to be making different decisions about who's incapable or a home making different decisions or different allegations when trying to define "incapable." So is there a standard term that is referenced that can be included, just so we all know?

**Ms. Smith:** I'd ask my colleague to turn to motion 9, where we define "incapable." We accepted that this morning: "'Incapable' means unable to understand the information that is relevant to making a decision concerning the subject matter or unable to appreciate the reasonably foreseeable consequences of a decision or a lack of decision...."

**Ms. Martel:** Okay. I appreciate that. Can I ask one other question? In this particular case, is it the executive director of the home who makes that decision or the determination of "incapable" itself for the purposes of this act?

**Ms. Smith:** Sorry, I'll just see. Chair, can I have legal counsel address this? Is that appropriate?

**The Chair:** Yes, that's fine. If you would take a chair and state your name, please.

**Ms. Bella Fox:** Bella Fox, legal counsel, Ministry of Health. This is a provision that creates an offence. So the decision would be made as to whether the person was incapable at the time a decision was made to proceed with a prosecution under this section. We're saying that those who are incapable would not be subject to prosecution.

**Ms. Smith:** So in order to use the defence, the court would determine whether or not the person was capable at the time.

**Ms. Martel:** I'm trying to figure out how you even get that far, if you understand what I mean. How would you get to the point of even having an offence provision?

**Ms. Fox:** You would have to have a determination made or an assessment done that the person was capable

at the time that they provided the information, or else you couldn't proceed with the offence provision.

**Ms. Martel:** Okay. And you would normally do that between the home, between the director and—it would work in that way?

**Ms. Fox:** The crown is going to proceed with the prosecution, so it would be the evidence that was presented to make a case for prosecution. If the evidence showed that the person was incapable at the time, then you couldn't proceed with the prosecution.

**Ms. Martel:** But who would even have the crown become involved, then? There's a step here that I'm missing. Someone would have to go to the crown and say—

**Ms. Smith:** This is how I see it, and, Bella, you'll correct me. An individual would lodge a complaint that includes false information in a report to the director. The person against whom the complaint has been lodged would say that it includes false information. Then we would look at who lodged a complaint in the first place—a resident. Is the resident protected under subsection (2)? This is only looking at our revised subsection (2). Then the question would be, is that resident capable or incapable?

**Ms. Martel:** I'm still assuming, through that process, that it's probably the director who's going to make that decision, right, because the complaint has to go to the director.

**Ms. Smith:** Right. But because it's an offence provision, it would actually be the court that's determining whether or not the person was incapable and could use the defence under subsection (2).

**Ms. Martel:** Okay. It was the step in there of having it go even that far and how that would happen.

**Ms. Smith:** What we're intending to do by protecting those who are incapable is, before that complaint goes any further, they would determine if that person is incapable or not; so, should this be an offence or not? We're trying to give some protection to them.

**Ms. Martel:** I'll live with that. Thanks.

**Mrs. Witmer:** Forgetting the words "capable" or "incapable," in taking a look at this section, which relates to reporting certain matters to the director and then this exception for residents, I guess the interpretation by some of the people who made presentations before this committee was—and I want to go back to the OMA, who are saying that they would be hesitant to recommend employment to their members in long-term-care homes under circumstances where they, meaning the doctor, may be subject to frivolous or vexatious complaints without repercussions. Then, you hear the Schlegel people saying that this section excludes residents from being truthful. So what protection is there for individuals against whom knowingly false statements and reports are made to the director? What consequences are there for the residents, who may be capable but are making these complaints?

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**Ms. Smith:** Well, now you're back in the capable-incapable argument. With your provision, all residents

could be found guilty of an offence if they have provided information that they know to be false. With our provision, we're saying that only residents who are capable could be found to be guilty of an offence if they provide information that they know to be false. So what protection is there for a member of the medical profession? That someone will be found to be guilty of an offence if they have knowingly given false information. Taking the resident out of the equation, if anybody does that, they're found to be guilty of an offence under this act. With a resident, we're saying if they're incapable, they're not guilty.

**Mrs. Witmer:** You're saying that in subsection 22(3)?

**Ms. Smith:** We're saying that in our motion number 96.

**Mrs. Witmer:** So you feel that your motion would protect all of the staff from any frivolous complaint?

**Ms. Smith:** Yes, and it would also protect a resident who is incapable, because we can't always predict what they will do.

**Mrs. Witmer:** Okay.

**Ms. Smith:** So we're still talking about your motion number 95.

**Mrs. Witmer:** Right. Then I would withdraw my motion.

**The Chair:** Okay, thank you. Before we do the next motion, just for committee business, there is agreement, I understand, to go till 4:30 today, and there is also agreement to start at 9 o'clock tomorrow morning. There was an example of blatant tardiness this morning, and I would ask that it not happen again.

**Mr. Lou Rinaldi (Northumberland):** Should the Chair set an example?

**The Chair:** I set a bad example this morning. I will set a good example tomorrow.

**Mr. Leal:** I was stuck in traffic, Chair.

**The Chair:** You were still here ahead of me.

**Mr. Leal:** There are better highways out of Peterborough.

**The Chair:** You may have been the slowdown, in fact, at the front of the line.

Coming now to government motion number 96.

**Ms. Smith:** I believe we've already had our discussion around this one.

I move that subsection 22(3) of the bill be amended by adding "who are incapable" after "does not apply to residents" at the end.

**The Chair:** Any additional discussion? I will call the vote. Those in favour? Opposed? It is carried.

Government motion number 97.

**Ms. Smith:** I move that subsection 22(4) of the bill be struck out and the following substituted:

"Duty on practitioners and others

"(4) Even if the information on which a report may be based is confidential or privileged, subsection (1) also applies to a person mentioned in paragraph 1, 2 or 3, and no action or other proceeding for making the report shall be commenced against a person who acts in accordance

with subsection (1) unless that person acts maliciously or without reasonable grounds for the suspicion:

"1. A physician or any other person who is a member of a college as defined in subsection 1(1) of the Regulated Health Professions Act, 1991.

"2. A person who is registered as a drugless practitioner under the Drugless Practitioners Act.

"3. A member of the Ontario College of Social Workers and Social Service Workers."

This rewording of this provision actually is just for clarity. It kind of parses out the components of the section, and it adds to it the drugless practitioners because we didn't want to lose naturopaths and others under the Drugless Practitioners Act.

**The Chair:** Any other discussion? I'll call the vote. Those in favour? Opposed? Carried.

I will now ask, shall section 22, as amended, carry? Those in favour? Those paying attention? Thank you. That is carried.

That brings us to government motion number 98.

**Ms. Smith:** We withdraw government motion number 98.

**Ms. Martel:** Chair, may I just ask a question? Do these provisions appear somewhere else, then? That's the second time. It's the same provision, and I just wasn't clear on what you were trying to get at.

**Ms. Smith:** I can't just withdraw, just because I decide to?

**Ms. Martel:** Not when it happened twice with the same wording.

**Ms. Smith:** Well, the wording—

**The Chair:** We don't normally debate a withdrawn motion.

**Ms. Smith:** The amendment was supposed to bring it in line with the initial part, where it says, "any of the following has occurred or may occur." Actually, the other one was more clear on this. So we had "resulted in or may result," but we think "has occurred or may occur" captures it.

**The Chair:** Okay. PC motion number 99.

**Mrs. Witmer:** I move that subsection 23(5) of the bill be struck out and the following substituted:

"Other inquiries

"(5) If the director receives information from any source about the operation of a long-term care home, and is not required to have an inspector conduct an inspection or make inquiries into the matter, the director shall disclose the information to the licensee or the licensee's delegate."

This is just making it mandatory for that to happen; that is, to notify the licensee.

**The Chair:** Any discussion?

**Ms. Smith:** We have motion number 100, which we'll discuss, which makes clearer our position on who should be notified.

**The Chair:** I will call the vote on motion number 99. Those in favour? Opposed? It is lost.

That brings us to government motion number 100.



**Ms. Smith:** I move that subsection 23(5) of the bill be struck out and the following substituted:

“Other inquiries

“(5) If the director receives information from any source about the operation of a long-term care home, and is not required to have an inspector conduct an inspection or make inquiries into the matter, the director may disclose the information to another person, including the licensee, or to the residents’ council or family council.

“Licensee to be notified

“(5.1) If the director discloses the information to the residents’ council or family council under subsection (5), the director is required to provide the information to the licensee.”

This is just to clarify that if that direction is made to the residents’ council or the family council, then the licensee is definitely provided with the information.

**The Chair:** Any discussion? I will call the vote. Those in favour? Opposed? It is carried.

I will now ask the question. Shall section 23, as amended, carry? Carried.

It is carried, moving us to NDP motion number 101.

**Ms. Martel:** I move that section 24 of the bill be amended by adding the following subsection:

“Justice with dignity

“(2.1) Where a person alleges that he or she has been dismissed from a position as a staff member contrary to subsection (1), the person shall be reinstated in the position until the licensee establishes that the dismissal was not a prohibited retaliation.”

ONA made this recommendation to us. In their submission, they said it uses federal legislation language with respect to whistle-blowers, and they felt that made the whole notion stronger that someone shall be reinstated. That hopefully will result in more people coming forward and not being concerned that, by coming forward, they would end up losing their jobs until it could be proven that that loss was directly related to an employer or a licensee trying to retaliate.

**The Chair:** Discussion?

**Ms. Smith:** This would in fact create a permanent stay. We don’t think that that’s appropriate. Any person who is found to be caught by subsection 24(2) can be reinstated and made whole by the reinstatement and/or the provision of damages. We would note that subsection 25(2) cross-references the Labour Relations Act, and under the Labour Relations Act, one of the remedies for discrimination is an order to reinstate. So there’s nothing precluding an arbitrator from reinstating, but this would create a permanent stay to that point, and we don’t support that.

**The Chair:** If there’s no additional debate—

**Ms. Martel:** I just wondered how it created a permanent stay if it also said, “The licensee establishes that the dismissal was not a prohibited retaliation.” Doesn’t that afford the licensee an opportunity to make those arguments?

1330

**Ms. Smith:** But this would ensure that you were reinstated “until the licensee establishes,” until the arbitration, which is a stay of the dismissal until an arbitration, which is not the normal collective bargaining process.

**Ms. Martel:** On the flip side of that, though, what is there to encourage an employee from whistle-blowing if the result of that would be that they would be dismissed and would have to go through arbitration in order to prove that they were dismissed because of retaliation? So now you have someone who has lost their job and is not employed until such time that it can be proved at an arbitration that they were dismissed because of retaliation. I think this works the opposite way, that they can continue in their position, continue to earn an income, until such time as the licensee or the employer can prove something else. So I’m just concerned about where the onus falls, then, and if you’re not really making it difficult for a staff person to make a choice about whistle-blowing if they think that for a period of time it will leave them without any income.

**Ms. Smith:** The onus is already on the licensee to establish that the dismissal was not prohibited retaliation, so the onus is clearly on the licensee. In your language you say “until the licensee establishes.” That would be at an arbitration. There’s no other mechanism where a licensee could establish or meet the onus. The arbitration provisions allow for reinstatement and damages, so they would be made whole at that time.

**Ms. Martel:** I understand that. The question is, how long does it take to get to arbitration? Making it whole at that time might be fine if you’ve got another source of income coming in to carry you through that period. My concern would be that even the prospect of being made whole because you have a good case is going to stop someone from whistle-blowing because they just can’t wait that period of time to be out of work and out of pay. Do you know what I’m getting at? Do you see what I’m saying?

**Ms. Smith:** I know what you’re getting at, but we don’t want to get involved in the actual negotiation of collective agreements, nor do we want to start gerrymandering the arbitration process. There is a process in place for dealing with conflicts between employees and employers that is covered by a collective agreement. This would create an exceptional circumstance where we would actually be staying a dismissal until an arbitration is heard. What I would be worried about is that anyone would say, despite whatever reason they were terminated for, “Well, I’m going to initiate my whistle-blowing protection. You in fact didn’t terminate me for X; you terminated me for whistle-blowing. Therefore, I want to be reinstated immediately until we determine what I was terminated for.” It would provide a protection that anyone could try and institute.

**Ms. Martel:** But if these are the provisions under federal law, don’t we have a precedent set already?

**Ms. Smith:** I’ve never seen these provisions under federal law, and the federal legislation that we were

pointed to by CUPE did not address the issue that was raised.

**Ms. Martel:** The one that I used was not raised by CUPE, it was raised by ONA.

**Ms. Smith:** I'm not familiar with the federal legislation that you're referring to, but this is similar to the Occupational Health and Safety Act as it stands in Ontario, as well as the new Public Service Act.

**The Chair:** Can I call the question?

**Ms. Martel:** I'm reading from the ONA brief; I'll just put this on the record, and then I'll leave it.

Page 15 of the ONA brief says, "Section 24 does not have the same level of protection for whistle-blowers as is contained in federal legislation. For example, section 24 does not have the limited 'justice with dignity' provision found in the federal accountability legislation where discharged whistle-blowers are reinstated in some cases until the employer proves just cause for discharge."

They reference footnote 29; I'm just looking to see if it's a report. The reference is, "See section 201 in Federal Accountability Act that amends section 19.6 in the Public Servants Disclosure Protection Act." Is there no interest at all in having a look at the federal legislation to see if we can incorporate some of it?

**Ms. Smith:** There was federal legislation referenced by CUPE, and we did look at that particular piece of legislation. I'm not sure if it's this one—

**Ms. Martel:** No.

**Ms. Smith:** —and I'm trying to confirm that.

**Ms. Martel:** I've got a copy of the brief, if somebody wants it. I'm referencing page 15 of ONA's brief right now. Page 26 gives the references, and the reference here was to 29, which looks at some other acts.

**Ms. Smith:** I appreciate your point and your position, but I think we would prefer to have consistency with the Occupational Health and Safety Act and other provincial legislation that's already in place. So I think we can call the question.

**The Chair:** I will call the question.

**Ms. Martel:** Can I have a recorded vote?

### Ayes

Martel.

### Nays

Fonseca, Leal, Ramal, Rinaldi, Smith.

**The Chair:** The motion is lost.

That brings us to government motion 102.

**Ms. Smith:** I move that subsection 24(6) of the bill be struck out and the following substituted:

"May not encourage failure to report

"(6) No person mentioned in paragraphs 1 to 4 of subsection (5) shall do anything to encourage a person to fail to do anything mentioned in clauses (1)(a) to (c)."

What we're doing in this amendment is just a rewording to be clear, so it's "shall do anything to encourage a

person to fail" as opposed to "reward a person for failing."

**The Chair:** We'll call the vote. Those in favour? Opposed? Carried.

I will now ask the question. Shall section 24, as amended, carry? It is carried.

That brings us to PC motion 103.

**Mrs. Witmer:** I move that subsection 25(1) of the bill be struck out and the following substituted:

"Complaints about retaliation

"(1) Where a staff member complains that an employer or person acting on behalf of an employer has contravened subsection 24(1), the staff member may,

"(a) if there is a collective agreement in place, have the matter dealt with by final and binding settlement by arbitration; or,

"(b) if there is no collective agreement in place, may file a complaint with the board, in which case any rules governing the practice and procedure of the board apply with all necessary modifications to the complaint."

This is almost word for word the same as what's there. It just provides a little more clarity.

**Ms. Smith:** Not quite, Mrs. Witmer. Your amendment would require that if there is a collective agreement in place, the staff person would only have recourse to the collective agreement, and if there's no collective agreement in place, they could go to the board. What we're doing in subsection 25(1) as drafted is to ensure that an employee has the right to go either through their collective agreement to arbitration or to the board. The reason for that flexibility is that in situations such as those we're referring to in section 24, the whistle-blower protection, there is sometimes some controversy within a union as to whether or not a union wants to take that complaint forward. Not casting any aspersions on anyone, but we do want to give the flexibility or the ability to a worker to go straight to the board and not have to rely on their union to take forward a complaint, in case there is a situation where there are two union members involved. We wouldn't want intra-union conflict to stop them from having their say as an individual worker. As well, the Occupational Health and Safety Act in Ontario allows for a worker to go through both venues.

**The Chair:** I will call the vote.

**Ms. Smith:** Sorry, I should just clarify: It's not both venues; it's either venue. I want to make sure it's not that they have both. It's either, but it is their choice.

**The Chair:** I will call the vote. Those in favour? Those opposed? The motion is lost.

That brings us to PC motion 104.

1340

**Mrs. Witmer:** This takes us to complaints.

I move that subsection 25(4) of the bill be struck out.

This is the part that deals with complaints to the Ontario Labour Relations Board. As the section on onus of proof is currently worded, there is a presumption of guilt here on the operator until proven innocent, which is somewhat contrary to the normal rule.



**Ms. Smith:** I would just note that in the new public service legislation on whistle-blowing protection, subsection 140(13):

“Onus of proof

“On an inquiry into a complaint filed with the Public Service Grievance Board, the Ontario Labour Relations Board or the Grievance Settlement Board under this section, the burden of proof that an employer or a person acting on behalf of an employer did not act contrary to subsection 139(1) lies on the employer or the person acting on behalf of the employer,” which is the mirror language to what we have in our legislation.

**The Chair:** If there’s no further debate, I will call the question. Those in favour? Those opposed? It is lost.

Shall section 25 carry? Carried.

That brings us to government motion 105.

**Ms. Smith:** I move that section 26 of the bill be amended by adding “where the provision of the information is required or permitted by this act or the regulations” at the end.

This is just for clarity. The section as it read previously was rather broad, and we just want to make sure that it’s where the provision of the information is required or permitted, not just any information any time.

**The Chair:** If there is no debate, those in favour? Opposed? It’s carried.

Shall section 26, as amended, carry? Carried.

That brings us now to section 27. Shall section 27 carry? Carried.

Now to section 28, government motion 106.

**Ms. Smith:** I move that paragraph 4 of subsection 28(1) and subsection 28(4) of the bill be amended by striking out “or pharmaceutical agent” in each case.

We’ve determined that “drug” will be defined in regulation and we wanted to ensure that natural products are included. “Pharmaceutical agent” does not adequately ensure that natural products are captured, so in the regulation we’ll be ensuring that “drug” captures everything that it should.

**The Chair:** If there’s no further debate, those in favour? Opposed? Carried.

That brings us now to government motion 107.

**Ms. Smith:** I move that paragraph 5 of subsection 28(1) of the bill be struck out and the following substituted:

“5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 30 or under the common law duty described in section 34.”

**The Chair:** No debate? Those in favour? Opposed? Carried.

That brings us to PC motion 108.

**Mrs. Witmer:** I move that subsection 28(5) of the bill be amended by striking out “unless the resident is prevented from leaving.”

Currently, it reads, “The use of barriers, locks or other devices or controls at entrances and exits to the home or

the grounds of the home is not a restraining of a resident unless the resident is prevented from leaving.” We’ve removed that.

The Ontario Long Term Care Association did speak to this, as did OANHSS, as did the Ontario Hospital Association and the Ontario Association of Residents’ Councils. There was some concern that unless this type of amendment were made, the residents may well be considered restrained the day the act is proclaimed simply by living in a long-term-care home.

**Ms. Smith:** We’ve addressed some of the concerns of the OLTCA by our definition of secure unit. Through the various amendments that we’ve made up to this point, we’ve determined that “secure unit” is a section of the home that will be defined in the legislation. We’re ensuring that the rights advice is provided if someone is moving into a secure unit.

With the previous amendment, we are ensuring that residents who go into a home that have the padlocks are considered to be restrained if they’re not given the code, but we would include in their plan of care whether or not they’re required to give the code. If they are not going to be given the code and it’s included in their plan of care and they consent to their plan of care, then we’re all done. If they are given the code, then they’re not restrained.

**Mrs. Witmer:** Would you just review that again? Over 60% of the residents have some form of dementia. What are you saying about the code?

**Ms. Smith:** I’m saying that if it’s determined in their plan of care that we shouldn’t be giving them the code, then it would be an issue of consent to the plan of care. They would not be getting rights advice or the other protections as we’ve defined for restraint. That would be for those residents. If they are given the code, then they’re fine. Obviously there’s no issue. The codes are simply there for protection generally and are part of the building code standards. If they are being moved into a secure unit as we’ve defined it at that point, then the rights advice and the protections around the use of restraints are instituted, except for the hourly—what’s the word I’m looking for?

**Ms. Martel:** Reporting.

**Ms. Smith:** —the reporting—thank you—which would not be required. I think that’s a subsequent amendment we haven’t got to yet.

**Ms. Martel:** That’s actually what I was going to ask. I just want to clarify that. If you’re not given the code and you agree to that, which essentially becomes a restraint, you’re not saying that the home has to report that.

**Ms. Smith:** No. That would be part of their plan of care. That would not be considered the institution of a restraint. It’s only when they go into a secure unit that we have to give them rights advice and only if they are restrained in a secure unit, i.e., use of restraints. Then you’d have to document that, but the mere existing in a secure unit is not going to require the documentation. I think that’s the subsequent amendment that we haven’t got to yet.

**Ms. Martel:** Or the fact that you don't have access to a code.

**Ms. Smith:** Yes.

**Ms. Martel:** I get it.

**The Chair:** I'll call the question. Those in favour of the motion? Those opposed? The motion is lost.

NDP motion 109.

**Ms. Martel:** Based on that discussion and the clarifications, I will withdraw this amendment.

**The Chair:** With 109 withdrawn, I will now ask, shall section 28, as amended, carry? It is carried.

That brings us to section 29, government motion 110.

**Ms. Smith:** I move that paragraph 2 of subsection 29(2) of the bill be struck out and the following substituted:

"2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1."

This is just to clarify that we're only trying them where appropriate. We're not insisting that they be tried if it's not appropriate.

**The Chair:** I will call the question. Those in favour? Opposed? It is carried.

Shall section 29, as amended, carry? It is carried.

That brings us to section 30, government motion 111.

**Ms. Smith:** I move that paragraph 2 of subsection 30(2) of the bill be struck out and the following substituted:

"2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1."

Again, the same rationale as our previous motion.

1350

**The Chair:** I can't say "same vote," so I will ask for those in favour. Opposed? Carried.

Moving to PC motion number 112.

**Mrs. Witmer:** Before I move it, can I ask the government if they feel that this has been addressed?

**Ms. Smith:** I think what you're doing here is to remove all consent and rights advice. What we've done is limit when you're required to give consent and rights advice to those moving into a secure unit. Your motion actually guts that.

**Mrs. Witmer:** I guess with all the changes that have been introduced by the government on this bill, it becomes difficult to determine whether some of the motions that we've put in place here are actually covered within other parts.

**The Chair:** I don't wish to be picky, but if we're going to debate this motion, you probably need to move it.

**Mrs. Witmer:** Okay. I will move that subsections 30(4), (5), (6) and (7) of the bill be struck out.

Again, the ability to move the residents within a home to a more appropriate level of care is important. There are lots of issues that are created here concerning that admission. We always have to balance a resident's right,

a resident's safety, and that's always an issue when you're transferring someone to a secure unit. So there's an attempt here to ensure that all of the necessary precautions of rights and safety have been taken into consideration.

**Ms. Smith:** There's nothing in the legislation that would supersede section 34, which is the common law duty that a caregiver can "restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others." What we're doing through subsections 30(4) to 30(7) is to provide rights advice for someone who is about to lose their freedom. We think that's incredibly important, and certainly we're supported in that by the Advocacy Centre for the Elderly and other advocacy groups on behalf of residents. We think that is a necessity before someone is moved into a secure unit in a home.

**Mrs. Witmer:** Is the ministry going to be adding rights advisers at all?

**Ms. Smith:** We understand that the capability is there now to deliver the rights advice, and in the legislation we require that it be done promptly. So if your issue is timing, which I know was raised by some, section 34 still allows for a crisis intervention if there's an issue of timeliness. As well, section 47 of the Health Care Consent Act allows for crisis situations, so we do have two mechanisms to address if something needs to be done quickly. But the legislation does require that they receive—I would note, under subparagraph 30(4)1, "shall promptly give the resident a written notice," "shall promptly notify a rights adviser." So we do intend to move promptly.

**Mrs. Witmer:** Because that certainly was one of the concerns that had been addressed—the potential for a wait list to be established within the home—and that already adds pressure to the external—

**Ms. Smith:** And again, through our assessment process, prior to placement we do have the opportunity, where there is a wait list, to make sure that if someone is actually coming—this is a different section—from the outside into a secure unit in the home, they get that rights advice prior to admission. So that process can happen while they're still on the waiting list, and we can ensure that the appropriate consents and rights advice are given.

**Mrs. Witmer:** I would withdraw that motion, then. Those concerns hopefully will be further addressed by the government.

**The Chair:** That moves us to government motion 113.

**Ms. Smith:** I move that subsection 30(5) of the bill be amended by striking out "and" at the end of clause (b), by adding "and" at the end of clause (c), and by adding the following clause:

"(d) of any other matters provided for in the regulations."

When we have to give written notice to a resident of their rights with respect to consent and rights advice, we just want to be able to provide them with other information.



**The Chair:** If there is no debate, I will call the question. Those in favour? Those opposed? Motion is carried.

I shall now ask, shall section 30, as amended, carry? Carried.

Section 31: We move to government motion 114.

**Ms. Smith:** Ms. Martel had a concern about PASDs and withdrew hers, so this is where the definition appears in the legislation: subsection 31(2).

I move that the definition of "PASD" in subsection 31(2) of the bill be amended by striking out "intended to" and substituting "used to."

We just didn't want a limit to those devices that are only "intended to" be used, because some devices that aren't actually intended to be used are "used to." We want to be able to capture those as well.

**The Chair:** I will call the question. All those in favour? Opposed? It's carried.

That brings us to PC motion 115.

**Mrs. Witmer:** I'm going to withdraw that motion.

**The Chair:** That brings us to government motion 116.

**Ms. Smith:** I move that paragraph 1 of subsection 31(4) of the bill be struck out and the following substituted:

"1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living."

Again, this is "where appropriate," the language that we were using in previous references to restraints.

**The Chair:** No discussion? Those in favour? Opposed? It is carried.

Shall section 31, as amended, carry? It is carried.

Moving now to section 32: government motion 117.

**Ms. Smith:** I move that section 32 of the bill be struck out and the following substituted:

"Records, reporting on restraining of residents

"32. Every licensee of a long-term care home shall keep records in the home, as provided for in the regulations, in relation to the following:

"1. The restraining of a resident, other than a restraint permitted under section 30.

"2. The use of a PASD, within the meaning of section 31."

We heard a great deal about paperwork. In our attempt to streamline the paperwork, we noted that submitting the reports to the directors could be considered onerous, so we are asking that they keep the records in the home. As well, the addition of "1. The restraining of a resident, other than a restraint permitted under section 30" would address the opposition members' concerns and some of the concerns of our presenters about the need to document environmental restraints, including secure units. So that would be the no-notes-every-hour provision.

**The Chair:** Discussion? Those in favour? Opposed? It is carried.

Shall section 32, as amended, carry? Carried.

Shall section 33 carry? Carried.

We now have government motion 118.

**Ms. Smith:** I move that subsections 34(3) and (4) of the bill be amended by striking out "or pharmaceutical agent" wherever that expression appears.

Again, Mr. Chair, it is similar to the language we used earlier defining drugs in regulation.

**The Chair:** I call the vote. Those in favour? Opposed? Carried.

Shall section 34, as amended, carry? Carried.

Bringing us to PC motion 119.

**Mrs. Witmer:** I move that section 35 of the bill be struck out and the following substituted:

"Ombudsman

"The government shall establish a third-party disputes resolutions mechanism to,

"(a) assist and provide information to residents, their families and others;

"(b) act as an advocate for residents, their families and others or make a referral to a more appropriate advocate when the resident, family member or others feel unempowered and are unable to advocate for themselves;

"(c) advise the minister on matters and issues concerning the interests of residents;

"(d) resolve disputes between the licensee and the ministry; and,

"(e) perform any other functions provided for in the regulations or assigned by the minister."

#### 1400

This would effectively eliminate the suggestion of the minister to establish an office of the long-term-care homes resident and family adviser.

We heard from OANHSS that they were disappointed that the original concept of an ombudsman office, as described in the commitment to care, had not been included in the act and instead we have this office of the long-term-care homes resident and family adviser. They still believe it's important to have an advocate available to residents, families, licensees, in mediating concerns and conflict and negotiating solutions and when the residents and families are not able to navigate the system themselves and when the licensee cannot resolve disputes it has with the ministry through the appeal or other processes.

This particular issue of an ombudsman was also raised by the Psychiatric Patient Advocate Office and the Concerned Friends of Ontario Citizens in Care Facilities.

As I say, it is recommending a third party disputes resolution mechanism, but it is eliminating the office as provided for here in the legislation—and you'll see later that there's another recommendation to deal with this.

**Ms. Smith:** We did hear a great deal about this issue. Leading up to the creation and drafting of the legislation, we heard about the need for a third party adviser/advocate; we had much input, again, at the hearings about how people would like to see this structured. Some people want advice, some people want information, some people want advocacy, some people want dispute resolutions. There wasn't a great deal of consensus.

What we also heard and what I think is one of the things that the government is now considering is the fact

that there was not consensus around a long-term-care ombudsman or adviser or third party adviser, but someone to deal with seniors' issues, writ large. So we've engaged in a discussion with the seniors' secretariat to look at whether we can create some kind of third party adviser that would deal with all seniors' issues, including long-term care, home care and retirement homes.

So we won't be supporting the creation of this entity. We do believe that in the legislation we do have dispute resolution mechanisms in place that deal with the complaints issues quickly and effectively, and we do feel that we are providing a great deal more information than was provided previously. We will be keeping the office of the long-term-care homes and resident family adviser provision because it allows the government to create it, but we will be looking at, through the seniors' secretariat, a larger structure that could deal with the concerns that were raised by many who appeared before the committee.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is lost.

Number 120 is not a motion but is a notice. Do you wish to speak to it, Ms. Martel?

**Ms. Martel:** I would recommend voting against this section in its entirety. That recommendation was also made by the MS society, CARP, by PPAO, RCLO. Frankly, we've been advocating for some time for the current Ombudsman to have oversight capacity so that he can both provide advocacy and deal with complaints that arise in long-term care. So I think this section is not necessary from that perspective, because I think the current Ombudsman has all of the capabilities, the staff and the expertise to do what's here and, frankly, to go much further beyond.

I would also just like to make a point at this time that the seniors' advisory council, which gives advice to both the Ministry of Health and the minister for seniors' issues, put out a letter in 2005 very clearly stating that there should be an ombudsman for long-term care and that they had no confidence that someone who was not independent from the ministry was in a good position to deal with complaints or concerns of residents. So while I appreciate that the parliamentary assistant is saying they are asking the seniors' advisory council for input now, I can say that there was already a letter clearly on record that went to the minister from the council, which is made up of probably 13 different seniors' organizations, including the Royal Canadian Legion, Ontario Command, which very clearly pointed out their preference and what they wanted to see done. I think we should just deal with that letter and do what they requested both ministers to do probably as far back as May 2005. So I don't support this whole section, because I think we really should be moving to respond to the concerns that were already made, both by the Royal Canadian Legion and by the members, the organizations on the seniors' advisory council.

**Ms. Smith:** Just to the point of the seniors' advisory council: I have met with the council on a number of occasions, and they are actually also advocating for this

third party position to be responsible for not only long-term care but other issues dealing with seniors, including home care, which is often mentioned, and retirement homes, which is getting more play because we're doing the review right now of the retirement home industry. So I would just note that there likely is broader acceptance for the notion of the senior third party review advocate, ombudsman, whatever term it ends up being.

As well, which I didn't note in our previous discussion, there is talk of a federal ombudsman. We believe that it was part of the Conservative election platform, but I have not confirmed that. We understand that it's being looked at at a federal level, so we want to ensure that whatever we're doing at a provincial level is not going to be in conflict with whatever is created at the federal level. It's just kind of late-breaking news that they're looking at something.

**Ms. Martel:** The feds can do what the feds want to do. That's fine. From my perspective, Ontario's Ombudsman should have oversight functions of long-term-care homes. I don't know if the feds are going to move on it or when, but I think the current Ombudsman is in a position to do that and we should be moving towards that. Thanks, Chair. That's it.

**The Chair:** I will ask the question, then. Shall section 35 carry? Carried.

Bringing us now to section 35.1, PC motion number 121.

**Mrs. Witmer:** I move that the bill be amended by adding the following section:

"Ombudsman

"35.1 The Ombudsman appointed under the Ombudsman Act is also the Ombudsman of long-term care homes and may make any investigations and reports with respect to long-term care homes as he or she may make with respect to any matter to which the Ombudsman Act applies."

So this is just a continuation of the discussion we've been having. This is recommended, of course, by the Royal Canadian Legion, Ontario Command. They did express concern. They were quite upset; they were disappointed that Bill 140 did not include an ombudsman to protect the seniors who were residing in nursing homes and who, they believe, are some of our most vulnerable citizens. I think we certainly all support that. They believe that in December 2003 Mr. Smitherman did make some sort of statement regarding a long-term-care ombudsman, and they really were looking for Bill 140 to provide the necessary clause to expand the current mandate of the Ontario Ombudsman to include long-term-care homes and be in a position where that individual could independently investigate complaints of care. I think for those persons who are looking for something other than what the government is suggesting in the form of some office, they are looking for someone to be totally independent from government.

**The Chair:** I will call the vote. Those in favour? Opposed? The motion is lost.

That brings us to NDP motion number 122.



**Ms. Martel:** Although my amendment is very much similar to Mrs. Witmer's, I'm going to read it into the record anyway and just make some comments about it.

"Ombudsman

"35.1 The Ombudsman may exercise any functions with respect to the long-term care home sector in Ontario that he or she may exercise with respect to any matter to which the Ombudsman Act applies."

So the particular provision that I put forward would give oversight function to the current Ombudsman to both advocate for and deal with complaints, systemic included, that come out of the long-term-care sector. I think the current Ombudsman has both the staff and the investigatory powers, and frankly the history of dealing with complaints. If Mr. Marin's place there in the last two years or so has been any indication, that office is quite capable and in the best position to act independently to advocate for residents and their families—both advocate and deal with concerns.

1410

I just want to reiterate that the Royal Canadian Legion, Ontario branch, very strongly felt that they had a commitment in this regard, as per a meeting they had with the Minister of Health in his office in March 2005. Their view in this regard has not changed, and they are not convinced whatsoever that this office of the long-term-care home resident and family adviser was what the minister promised. Indeed, they are very clear that there was to be independence here, and I don't see that the current office that is established—or could be established, because it says "may"—under section 35 will in any way, shape or form be independent of the government itself.

So both the Royal Canadian Legion and the seniors' advisory council in 2005 were very strong on this position. The Multiple Sclerosis Society of Canada also supported an independent function and the Ombudsman exercising these functions. It was supported as well by SEIU, CAW and CUPE.

We need a forum where someone who is truly independent has the opportunity and has the responsibility for responding to systemic problems and concerns that arise at a long-term-care home. In the letter that was put forward to both Ministers Bradley and Smitherman in 2005, the seniors' advisory council made it very clear that they had no confidence that these issues could be dealt with internally, that there had to be someone independent. I think the way to respond to all of those concerns is to grant the current Ombudsman oversight capacity in this regard.

**Ms. Smith:** I just want to clarify that in Kingston, in their submissions, the Ontario Command clarified their position on their meeting with the minister and said that he had discussed with them an ombudsman-like role and not, in fact, an ombudsman; or at least that wasn't their position in Kingston.

I also just wanted to clarify that while the MS Society and the seniors' advisory group, as well as perhaps the SEIU, had looked for a third party that was independent

of government, I don't recall the MS Society or the seniors' advisory group asking that the current Ombudsman's role be expanded. I don't know if that was what you were saying. The independent third party, yes, but I don't think that either of those groups—I don't know about the SEIU—called for the expansion of the current Ombudsman's role. I just want clarity on that.

**Ms. Martel:** Just with respect to the Legion, who were very clear that the minister said, "ombudsman-like," they also made it clear in their submission that that didn't satisfy their concerns or that didn't mean for them the office of the long-term-care adviser that may be set up. So there is a clear distinction between what is proposed in section 35 and what the legion wanted, which is something that was far more independent. Under section 35, that office will not be independent of the government.

**The Chair:** I will call the question. Those in favour of the motion?

**Ms. Martel:** Can I have a recorded vote, Mr. Chair?

**The Chair:** Recorded vote.

**Ayes**

Martel, Witmer.

**Nays**

Fonseca, Leal, Ramal, Smith.

**The Chair:** The motion is lost.

That brings us to NDP motion number 123.

**Ms. Martel:** I move that subsection 36(2) of the bill be amended by adding the following clause:

"(a.1) governing temperature requirements for long-term care homes;"

This is the regulation-making section of the bill. Under this section, the Lieutenant Governor, i.e. cabinet, has the opportunity to make a number of regulations that affect various parts of this bill. This is a new addition. We had concerns raised, at least by CARP, about what was happening to long-term-care homes today as it becomes hotter and hotter in the summer. There are a number of long-term-care homes that aren't in a position, actually, to deal with residents' needs in that regard. They said specifically that Bill 140 should mandate that an air conditioning unit must be available in each long-term-care home to address the comforts and needs of residents and staff.

I didn't use that particular wording, but I do think the principle is one that we need to think about. Times are changing in terms of climate change and residents in long-term-care homes are frail, are elderly. In some of the sweltering heat last year, I do know that even my colleague Ms. Horwath had complaints from a number of residents in homes in her riding about the unwillingness of the operator to do anything to respond to that. I think this is an issue we need to get our heads around, and I ask for it to be put in the regulation section so the government would have the opportunity to do some work on it.

**Mrs. Witmer:** I would strongly support this motion. It was one that we had intended to introduce.

This past summer, we heard from individuals who found the temperatures within the homes uncomfortable. We heard primarily from family members who were concerned about their loved ones. I think part of the reason we're starting to hear about it now is that, number one, we have more residents than ever before living in homes. Many of them obviously have many more complex needs than in the past. Also, we seem to have a situation worldwide where temperatures are increasing, and more and more people in their own personal homes are looking to air conditioning to be more comfortable. So it really is something that needs to be considered within the regulations.

**Ms. Smith:** I feel compelled to weigh in, because I have to remind my colleague again that it was her government that set the building standards that didn't include air conditioning. It's just so unfortunate. But I appreciate that we're all supporting this NDP motion and we will see the work done in regulations.

**The Chair:** I will call the vote, then. Those in favour of the motion? Opposed? It is carried.

That brings us to government motion 124.

**Ms. Smith:** I move that subsection 36(2) of the bill be amended by adding the following clause:

"(d.1) defining 'regular nursing staff' for the purposes of subsection 7(3);"

This is just for clarity. We had some questions raised as to whether regular nursing staff meant full time, part time, both or something else, so we want to be able to define that in the legislation.

**The Chair:** Those in favour? Opposed? Carried.  
Government motion 125.

**Ms. Smith:** I move that clauses 36(2)(f) and (g) of the bill be amended by striking out "clarifying" wherever it appears and substituting in each case "specifying."

Again, this is just for clarity, even though we're specifying.

**The Chair:** Any lengthy debate? I'll call the vote. Those in favour? Opposed? It is carried.

This moves us to government motion 126.

**Ms. Smith:** I move that subsection 36(2) of the bill be amended by adding the following clause:

"(g.1) defining 'drug' for the purposes of this part;"

As many of you have noted, I've referred to the fact that we'll be defining "drug" in the regulations, so that's why this is here.

**The Chair:** I will call the vote. Those in favour? Those opposed? It's carried.

*Interjection.*

**The Chair:** No further discussion.

**Ms. Smith:** I wanted to withdraw it because we need to move it to the back of the bill.

**The Chair:** It's not carried. What was I saying?

**Ms. Smith:** Can I have unanimous consent to reopen discussion on clause 36(2)(g.1)?

**The Chair:** Agreed.

**Ms. Smith:** Thank you. I withdraw this motion.

**The Chair:** It is withdrawn.

**Ms. Martel:** Can I just ask where it's going?

**Ms. Smith:** We're putting it at the end in the regulation-making powers, so that when we define "drug," it applies to the whole act and not just this section.

**Ms. Martel:** So are we getting a new amendment?

**Ms. Smith:** Yes.

**The Chair:** You win motions you didn't even make.

We're still on section 36: PC motion 127.

**Mrs. Witmer:** I move that subsection 36(2) of the bill be amended by adding the following clauses:

"(i) clarifying, for the purposes of paragraph 4 of subsection 22(1) and paragraph 5 of subsection 23(1), what constitutes improper treatment or care;

"(j) clarifying, for the purposes of paragraph 4 of subsection 22(1) and paragraph 5 of subsection 23(1), what constitutes incompetent treatment or care."

**1420**

This really is intended to provide clarity in this whole area of regulation-making and specific inclusions. This inclusion is intended to address the fact that the whistle-blowing provisions are much broader than what was set out in the Nursing Homes Act and in order to support the intent of section 22.

There's also a concern that without further clarity, we could see increasing litigation and increasing resident expectations regarding the limits to medical care and health services. So I think that in order to avoid this, we need to clarify exactly what constitutes improper treatment or care or incompetent treatment or care to avoid that increasing litigation and to manage resident care and expectations.

**The Chair:** Ms. Smith?

**Ms. Smith:** We note that the term "improper treatment or care" is in the Nursing Homes Act and has never been defined, and we believe that has not been an issue to date. When the inspectors do receive complaints, they usually look at the standards of practice expected of a person by their own college; however, as we know, not everyone is regulated by a college. It would be very difficult to define treatment or care, though, to include any possibility. So we think that allowing the general notion of incompetent treatment or care to stand allows us to deal with it on a case-by-case basis, and we don't see the need to define it.

**The Chair:** I will call the question. Those in favour? Those opposed? It is lost.

Shall section 36, as amended, carry? Carried.

That moves us now to government motion 128.

**Ms. Smith:** I move that section 37 of the bill be struck out and the following substituted:

"Application of part

"37(1) This part applies to the admission of a person to a long-term-care home as a resident and any transfer within a home to a specialized unit.

"Transfer

"(2) Where a person is to be transferred to a specialized unit within the long-term-care home, this part applies as though the transfer were an admission of the



person to the home, even if the specialized unit is also a secure unit.

**“Definition**

**“(3) In this section,**

**“‘specialized unit’ means any unit designated by or in accordance with the regulations to provide or offer certain types of accommodation, care, services, programs and goods to residents, but does not include a secure unit unless the secure unit is designated as a specialized unit by regulation.”**

This is in order to allow for the creation of specialized units, as has been recommended in the Casa Verde inquest and others. There’s work under way at the ministry level on looking at behavioural or specialized units. This would allow the CCAC to deal with admissions to specialized units even for those inside the home to ensure that we’re not put into a situation where, in a centre that has more than one home but only one home with a specialized unit, those residents in that particular home have special access to specialized units while others from outside the home who may need a specialized unit are precluded. So by putting the placement onus at the CCAC level, we allow for everyone in the community and everyone in other homes who need the services of the specialized unit to be placed into that specialized unit.

**Ms. Martel:** I guess that would be based on as long as there are enough spaces, right? That’s going to be the dilemma.

**Ms. Smith:** Granted, but with the creation of one, we want to ensure that there’s fairness as to who has access to it.

**The Chair:** I will call the question, then. Shall the motion carry? Carried.

Shall section 37, as amended, carry? Carried.

Shall sections 38 and 39 carry? Carried.

That brings us now to NDP motion 129.

**Ms. Martel:** I move that section 40 of the bill be amended by adding the following paragraph:

**“3. The placement coordinator must have determined that the long-term-care home has sufficient staff and an appropriate physical setting to meet the care needs of the person without jeopardizing the care of existing residents.”**

The current section sets out some criteria that have to be used for a person to be admitted as a resident. This would be a third criterion, to make it really sure that for the resident coming in, there is sufficient staff to meet the needs. That was recommended by the Ontario Nurses’ Association.

**The Chair:** Parliamentary assistant?

**Ms. Smith:** We do not believe that it’s appropriate for the CCAC to be determining whether or not a home has the appropriate physical setting to meet the care needs. There are provisions in the legislation under subsection 42(7) to allow for a home to determine that they do not have the physical structure to accept the resident, and they must provide a detailed explanation of their determination under subsection 42(9). So we do have that

mechanism in place, and we do not feel it’s appropriate for the CCAC to make that determination.

**The Chair:** I will call the question. Those in favour? Those opposed? The motion is lost.

Shall section 40 carry? It is carried.

Moving now to section 41, we have PC motion 130.

**Mrs. Witmer:** I’m going to withdraw that motion in light of discussions past and what I know will be future.

**The Chair:** Okay. That brings us to government motion 131.

**Ms. Smith:** I move that paragraph 4 of subsection 41(5) of the bill be amended by striking out “persons” at the end and substituting “individuals.”

This is just for clarity, in order to determine that different individuals are making the assessment. “Persons” can be defined to include a corporation, and we wanted to make sure that it was two different individuals.

**The Chair:** Hearing that, can I call the question? Those in favour? Opposed? It is carried.

That brings us to NDP motion 132.

**Ms. Martel:** I move that subsection 41(6) of the bill be struck out and the following substituted:

**“Assessments, etc. to be taken into account**

**“(6) In determining whether or not the applicant is eligible for long-term care home admission, the placement coordinator shall take into account all of the assessments and information required under subsection (4) and such other information as the placement coordinator has that is relevant to the determination of eligibility, and if when the assessments and other information used to determine eligibility is presented to the long-term care home the licensee notes a gap in the assessments and other information, then the placement coordinator shall ensure that the information requested by the long-term care home is provided prior to an admission decision being required by the licensee.”**

This was submitted to us by OANHSS.

**Ms. Smith:** Again, I think that the required assessments under subsection 41(4) and our motion 141 will go some way to addressing these concerns. In our motion 141, we deal with a change in circumstance of a resident requiring a more up-to-date assessment. So we are, in the legislation as well as in our motion today, requiring that more up-to-date and more fulsome assessments are made, so I don’t believe that we’re going to have the same situation that we have here. This could put an unreasonable onus on the placement coordinator to provide information that’s difficult to access, so we want to make sure that assessments are done in a timely way, are the most up-to-date possible, and are as broad as can be. We think the legislation as it now stands will provide for that.

**Ms. Martel:** The only point I’d like to make is that, under the circumstances the parliamentary assistant is referring to, you already have a resident in the home. Part of what I was trying to capture here is that an admission would be questioned or even stopped if all of that information hadn’t been provided. So I think there’s a difference in terms of the assessments and what the requirements are that we’re dealing with.

**Ms. Smith:** I'm sorry, I don't understand your concern.

**Ms. Martel:** Right now, I'm saying that this information has to be provided from the placement coordinator to the long-term-care home even prior to an admission decision being made, so the resident is still not in the home. Correct me if I'm wrong, but my understanding is that the assessment changes you were making were a reference to a situation where residents were already in the home and assessments were occurring after that.

1430

**Ms. Smith:** No. Under subsection (4), the assessments are done prior to and have to be done—I'm sorry; I'm just looking for the section—within three months of placement: "The appropriate placement coordinator shall give the licensee of each selected home copies of the assessments ..."—this is subsection (7)—"that were required to have been taken into account, under subsection 41(6)"—so that's in determining whether they should be appropriately placed—"and the licensee shall review the assessments and information and shall approve the applicant's admission ... unless," and we put it in the negative when they're allowed not to accept somebody, so they have to accept somebody except in these limited circumstances. But they are given the copies of the assessment and the information that we refer to in the assessment process, so they're given it prior to making that determination. They are permitted to ask for more information—they are now; they will be in the future. But certainly, the assessments that we're now setting out in the legislation go a long way in addressing some of the concerns that have been raised about lack of information.

**The Chair:** I will now call for the vote on motion 132. Those in favour of the motion? Those opposed? The motion is lost.

Bringing us to government motion 133.

**Ms. Smith:** I move that subsection 41(9) of the bill be struck out and the following substituted:

"Review of determination of ineligibility

"(9) The applicant may apply to the appeal board for a review of the determination of ineligibility made by the placement coordinator, and the appeal board shall deal with the appeal in accordance with section 51."

Really, this is just for a matter of clarity. We're cross-referencing the appeal section, 51, that sets out the procedures for appeals.

**The Chair:** Any debate? I'll call the vote. Those in favour? Opposed? It is carried.

Shall section 41, as amended, carry? That's carried, bringing us to section 42, government motion 134.

**Ms. Smith:** I move that the definition of "appropriate placement coordinator" in subsection 42(2) of the bill be amended by adding "designated pursuant to subsection 38(1)" after "the placement coordinator."

This is just for drafting clarity and ease of reference in the legislation.

**The Chair:** I'll call the vote. Those in favour? Opposed? Carried, bringing us to PC motion 135.

**Mrs. Witmer:** I move that subsection 42(3) of the bill be amended by striking out "selecting" and substituting "applying to."

There is a one-word difference here. It talks about the placement coordinator and it says here that they assist the applicant in selecting a long-term-care home. We're suggesting here that that "selecting" become "applying," because their role normally is to help in the application process. The selection is usually made by the applicant and their loved ones.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** Actually, the language, as it now exists, is "selecting," not "applying." We feel that "applying" would be too limited. If someone came in and wanted to apply to a certain home only because that's the only home they've ever heard of, they may not be familiar with other options in their area or that are more culturally sensitive to their needs. We think it's broader to allow for the assistance with selecting, which will ensure that our residents are placed in the most appropriate home available for them.

**The Vice-Chair:** Further debate?

**Mrs. Witmer:** I hope that the placement coordinators would put the best interests of the resident and the family first and foremost, although I would have to say, based on some personal experience, in some instances more recently, because we have more people going into long-term-care homes, there has been some concern that some of the assistance that they've received has not led to them being overly happy with the selection that, in some respects, was made on their behalf. These people sometimes can be very easily influenced, and we need to be careful that people do actually get the home of their choice and not what the placement coordinator at the time would think be best. We've got to guard against that.

**Ms. Smith:** I would just note that in subsection 42(3), "The placement coordinator who determined that the applicant is eligible for long-term-care home admission shall, if the applicant wishes, assist the applicant in selecting..." Then also—this is subsection (4): "In assisting the applicant under subsection (3), the placement coordinator shall consider the applicant's preferences relating to admission, based on ethnic, religious, spiritual, linguistic, familial and cultural factors." So we are including some provisions there.

I would also note that under subsection 41(7), "If the placement coordinator determines that the applicant is eligible for long-term care home admission, the placement coordinator shall, at the time of making the determination, provide information to the applicant about the process for admitting persons into long-term care homes and explain the process, the choices that the applicant has in the process and the implications of those choices." We are trying to go some way to ensure that our residents are informed as best as possible about the process and what options they have in that process to avoid situations that you may be referring to.



**The Vice-Chair:** Further debate? All in favour of PC motion 135? Opposed? The motion is lost.

PC motion 136.

**Mrs. Witmer:** I move that subsection 42(5) of the bill be amended by adding “all” after “disclosure of,” which would then read, “written consent to the disclosure of”—instead of just “information” now, it would be—“all information necessary to deal with the application.”

This request to include the word “all” came from both OANHSS and the Ontario Long Term Care Association.

**The Vice-Chair:** Further debate? No debate. Motion 136: All in favour? Opposed? The motion passes.

NDP motion 137.

**Ms. Martel:** It’s the same as the one put forward by Ms. Witmer and it has been carried, so I will withdraw mine.

**The Vice-Chair:** PC motion 138. Ms. Witmer.

**Mrs. Witmer:** You know what? I will withdraw that. We’ve dealt with it in some respects. It has been rejected.

**The Vice-Chair:** Motion 138 withdrawn.

We move to NDP motion 139.

**Ms. Martel:** I move that subsection 42(7) of the bill be amended by striking out “or” after clause (b) and adding the following clauses:

“(b.1) the applicant’s assessed care requirements create a risk for other residents of the long-term-care home;

“(b.2) incomplete assessments and information have been provided by the placement coordinator; or”

This comes in the section of what has to be provided in the process around placement, and was proposed to us by OANHSS.

**Ms. Smith:** I believe that our government motion 141 will go some way to addressing these concerns by addressing the timeliness or the completeness of the assessments. We are going to be setting out criteria in the regulations for admission to different types of units.

**The Vice-Chair:** Any further debate? All in favour of NDP motion 139? Opposed? The motion is lost.

NDP motion 140.

**Ms. Martel:** I move that subsection 42(7) of the bill be struck out and the following substituted:

“Licensee consideration and approval

“(7) The appropriate placement coordinator shall give the licensee of each selected home copies of the assessment results or personal health profile that were required to have been taken into account under subsection 41(6), and the licensee shall review the results or profile and shall approve the applicant’s admission to the home unless,

“(a) the home lacks the physical facilities necessary to meet the applicant’s care requirements;

“(b) the staff of the home lack the nursing expertise necessary to meet the applicant’s care requirements; or

“(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

“Full report on request

“(7.1) The appropriate placement coordinator shall give the licensee the complete version of any assessment if requested to do so by the licensee.”

1440

This matter was raised with the committee early on by the Ontario Association of Community Care Access Centres when they were talking about information that would have to be provided by the placement coordinator. They referenced the fact that coordinators were using a personal health profile when they were making decisions and that that might be more appropriate than sending all kinds of information to the home. If the home wanted further information, that would certainly be provided for on request, but, in their view, the way the personal health profile had been developed and the way it’s currently being used should suffice for important and correct decisions to be made. It’s a reflection of what they said to us.

**Ms. Smith:** Actually, this is in complete contradiction to all the other things you’ve been saying, because the personal health profile, from my understanding, is a short-form profile and does not provide all the information that homes are looking for. We would have grave concerns with limiting the information to the personal health profile, and as this reads, it could be assessments “or.” Most of the homes that we’ve spoken to, and the operators, the licences want more information, so this limitation to the personal health profile would not meet their needs.

As well, under (7.1), which you’re wanting to add—“The appropriate placement coordinator shall give the licensee the complete version of any assessment if requested to do so”—they have to do that now.

**Ms. Martel:** They wouldn’t if the amendment that I put was in place. I listened to the parliamentary assistant say that in discussions they’ve had with homes and operators they want to provide more of the information. That’s contradictory to what the CCAC association actually told us on the record, which was that they are working with these profiles now. The reason why I moved it was because they, in their submission, were telling us that they were using that with a number of homes now. If that information is incorrect, that’s where it came from.

**The Vice-Chair:** Any further debate?

**Ms. Smith:** No. Let’s just call the vote.

**The Vice-Chair:** Okay. NDP motion 140: All in favour? Opposed? The motion is lost.

Government motion 141.

**Ms. Smith:** This is the section that I had been referring to previously.

I move that clause 42(11)(a) of the bill be struck out and the following substituted:

“(a) for each of the assessments required under subsection 41(4), either the assessment or a reassessment was made within the three months preceding the authorization of admission, or within the preceding three months there was a significant change in the person’s condition or circumstances, in which case a reassessment was made at that time;”

**The Vice-Chair:** Any further debate? No further debate. All in favour of government motion 141? Opposed? The motion carries.

NDP motion 142.

**Ms. Martel:** I move that clause 42(11)(a) of the bill be struck out and the following substituted:

“(a) for each of the assessments required under subsection 41(4), either the assessment or a reassessment was made within three months preceding the authorization of admission; unless the applicant is receiving current treatment from an acute care hospital or a mental health practitioner, in which case the placement coordinator shall access and provide current reassessment information and consult with the long-term care home prior to finalizing the admission.”

This came to us from OANHSS.

**Ms. Smith:** I think the change that we just made through motion 141, where we discuss significant change, is broader and captures what Ms. Martel is including here. As well, I would note that current treatment from an acute care hospital or a mental health practitioner does not encompass those who are in the community and who may have seen their doctor and there may have been a change. We're only looking at hospital care or mental health care here; we would not be seeing any significant change if someone just went to their family doctor. So we think that our provision that we just passed, that includes significant change, encompasses any significant change that a potential resident may have undergone and requires a new assessment.

**The Vice-Chair:** Any further debate? There's no debate. All in favour of NDP motion 142? Opposed? The motion is lost.

PC motion 143.

**Mrs. Witmer:** I move that subsection 42(11) of the bill be amended by striking out “and” after clause (c), by adding “and” after clause (d) and by adding the following clause:

“(e) the person or their substitute decision-maker, or both, have signed the admission agreement provided for in the regulations.”

This relates to the conditions of authorization of admission. There is no provision currently setting out the contractual obligations of the resident and substitute decision-maker upon admission to a long-term-care home. I think this bill does provide the opportunity for the ministry to address the accountability of residents and their families within the LTC home sector. Apparently, the issues that are of some concern to individuals within the sector are the issues of financial abuse and the mounting, growing bad debt. The bad debt obviously impacts not only those not-for-profits or for-profits who operate the homes, but it also impacts upon the government, which funds the homes. So it does at least allow us to move forward to address some of the bad debt that often is the result of financial abuse by the residents' families.

This particular amendment would clearly set out the obligations of the resident and the family in relation to

the admission to a publicly funded LTC home by identifying the limits to government funding and the accountability of the resident for room and board while receiving care in a long-term-care home. The ministry would require the placement coordinator to ensure that the portion of the prescribed admission agreement is signed as a condition of admission to a home. Again, it would address an issue which apparently is growing in some areas.

**The Chair:** Ms. Smith.

**Ms. Smith:** We have a motion that is in the pile to deal with bad debt, and we feel that this would be inappropriate because we have no ability to regulate what is in the admission agreement at this time. We would hesitate to enforce the signing of an admission agreement that could include inappropriate sections.

**The Chair:** Ms. Martel? No. I will call the question. Those in favour of the motion? Opposed? It is lost.

I will now ask—

**Ms. Martel:** On a point of order, Mr. Chair: I know we're going to vote on section 42 now, right?

**The Chair:** Section 42; correct.

**Ms. Martel:** Before we do that, I'd like to ask the parliamentary assistant a question to clarify something. Under section 11—that's the section we've just been dealing with—the coordinator may authorize the admission and then the criteria are set out. It's clause (d) that I'm most interested in, “the person provides consent to being admitted to the home.” Are you envisioning that these conditions, particularly (d), take effect as soon as the bill is passed?

**Ms. Smith:** I don't understand what you're getting at.

**Ms. Martel:** Let me tell you what I'm getting at. In our community, we have a crisis 1A designation now. I think Kingston is in the same position, and perhaps Windsor. So (d) is completely irrelevant in our community, because it doesn't matter if the person wants to go to that home or not; they have to, under the designation, go to the first available bed in the community. It may well not be the bed or home of their choice. So I'm trying to get clarification about how this works with our community, where we have this specific situation right now.

**Ms. Smith:** The crisis 1A designation does not preclude them from still staying on the waiting list to go to the home of their choice.

**Ms. Martel:** But they are not entering the home they want to go to. For example, three weeks out of four, admissions to long-term-care homes are done out of the Sudbury Regional Hospital, not from the community. It's the first available bed, so it has nothing to do with the resident's preference; they go to the first available bed. When they're in that long-term-care bed, in a home that was not their first choice, they can sit on a waiting list to try to get into their home of choice, but their reality right now is that they have no say and they have no ability to consent; they are automatically sent to the first available bed, regardless of where it is in the six homes in our community. So I see a contradiction there in terms of en-



sure that the resident can go to their bed of first choice, when communities like mine have this crisis designation.  
**1450**

**Ms. Smith:** The consent provisions are presently in the legislation. I understand what you're saying, but in the crisis situations that we've had, we've had to deal with that by placing people in their not first choice until their first choice comes along. I recognize that that's a bit of a contradiction, but this is consistent with what's there now. Certainly we are trying to deal with our crisis situations across the province as best we can.

**Ms. Martel:** I appreciate that. Maybe I can just add one more thing to this. I know the ministry is aware of this, but this is a particular crisis recently in Kingston and Windsor. For those people who were in the hospital and didn't want to go to the first bed that was open, the hospitals were then trying to apply a fee, which was quite significant. Now, that hasn't happened—

**Ms. Smith:** It hasn't happened.

**Ms. Martel:** —as far as I know, in Sudbury yet, but there was certainly that potential in Kingston and Windsor. The second thing I want to know is, what impact, if any, does this provision have on the hospital trying to do that?

**Ms. Smith:** Again, the Long-Term Care Homes Act does not govern how the hospitals behave or govern themselves. This legislation has no impact on hospital administration. We're trying to ensure that our residents are placed where they want to be placed, if at all possible, and only when we are in a 1A crisis do we supersede that by placing them elsewhere. The hospitals that you talked about have not charged those fees. The ministry has been working closely with those centres in order to try to address the needs and concerns, as we have with Sudbury on the 1A crisis situation over the last months and as we have in Kingston over the last months. Obviously, we've made announcements recently for new beds. That's going to take some time; there's no doubt about it. We're also introduced alternate-level care and interim beds in both of those centres to try to address the issue. We are using the tools we have available to try to address the issues of the residents.

**Ms. Martel:** I appreciate that. In Sudbury it has been two and a half years now that we've been under the crisis designation, so I'm fair to assume that this provision applies except in the cases where a community is under a crisis 1A designation by the ministry? It applies for other people, but if you're in the situation where the ministry has authorized a crisis 1A designation in your community, then (d) does not really apply, because you don't have a choice.

**Ms. Smith:** You still have to consent to be placed in that home. It's not your first choice—

**Ms. Martel:** But they don't even have that luxury, because three weeks out of four the discharges are being made out of the hospital, so they go to the first bed in any home. It doesn't necessarily mean it's their first choice. They could wait for a long time in what is not their first choice on a waiting list to get into what is their first

choice. So as I read this, the person provides consent to being admitted to the home. That's not happening. We have people who don't want to provide consent, but that's where they have to go.

**The Chair:** Legal counsel.

**Ms. Fox:** This provision is currently in the long-term-care homes legislation. It's continued in the bill. The bill also has the ability in regulation to exempt from provisions of the act. So the issue that you are addressing could be dealt with in the future by regulation to exempt people from provisions of the act. But, currently as worded in Bill 140, it continues what the current law is.

**Ms. Martel:** I don't want to see a provision for an exemption. I don't want to go there, because I want it to be dealt with.

**Ms. Fox:** Bill 140 will provide more flexibility in the future to address these kinds of situations with the regulation to exempt.

**Ms. Martel:** But if I'm correct, the regulation that you are talking about would be a regulation to exempt residents who find themselves in this situation; I'm not encouraging that. What I want to encourage is that people can go to the home of their choice, so—just to make it clear in the public record—I'm not here to encourage a regulation that would exempt Sudbury or other communities who are under this designation from this provision. I have to say that I don't see in the legislation what other provision there is to address this very situation that I'm bringing forward. I appreciate your advice on where else this is going to be resolved.

**Ms. Fox:** The issue can also be addressed in regulation in the future with respect to waiting list priorities. So in terms of who gets into a bed, even if it is a crisis situation, crisis now applies to people who are in hospital and people who are in the community etc., so there may be availability in the future to draft regulations that are more particular as to who gets the first crisis bed or who gets the second, who's in which waiting category. So priorities can be set by regulation, and we can address some of those issues in the future in the regulations under this new legislation.

**Ms. Martel:** Can I just ask one final thing? Are the designations that appear now, crisis 1A, and there's a number of them, set by regulation—

**Ms. Fox:** Yes, they are.

**Ms. Martel:** —or by policy? So they're set by regulation. That's what's in place, and that's what we have to live with at this point.

**Ms. Fox:** "Crisis" is the highest category on the waiting list.

**Ms. Smith:** But we should note that through Bill 140 we are including the concept of choice, which was actually argued against by certain stakeholder groups. Certain stakeholder groups wanted us to just move anyone out of a hospital into the first available bed, no matter if you were an 1A crisis or not. We've certainly not allowed that to happen. We've entrenched the ability to choose, and we've put in these protections. Only in those extreme circumstances, which we're not going to

resolve this afternoon, because they have gone on for some time and there are some systemic issues that we're trying to address as we try to manage the entire system—

**The Chair:** Okay. I will now ask the question. Shall section 42, as amended, carry? It is carried.

That brings us now to section 43, NDP motion number 144.

**Ms. Martel:** I move that paragraph 4 of subsection 43(1) of the bill be amended by adding “or the director of nursing and personal care or a registered nurse who is his or her delegate” after “extended class.”

This was put forward by OANHSS. I think there's going to be a friendly amendment to this, but I'll table it for now and then we'll work from there.

**Ms. Smith:** I have a friendly amendment; I hope it's friendly.

I would like to move that paragraph 4 of subsection 30(2), not subsection 43(1)—and I'll explain why in a second—of the bill be amended by adding “or the director of nursing or personal care or a registered nurse” after “extended class”.

So we would take out “who is his or her delegate.” The reason for that is that in this situation what I think Ms. Martel was looking at was having the director of nursing and personal care or a registered nurse involved in the transfer to a secure unit within a home, not from the community. Subsection 43(1) deals with transfers to a secure unit from the community. Subsection 30(2) deals with transfers within a home, so I think it would be more appropriate for the director of care of that home to be involved in that transfer than to be involved in a community transfer.

**The Chair:** Your amendment deletes “who is his or her delegate.”

**Ms. Smith:** And changes subsection 30(2) for subsection 43(1).

**The Chair:** Okay. Any discussion on the amendment?

**Ms. Smith:** Just to be clear, it's “or the director of nursing and personal care.” I think I said “or” but I meant “director of nursing and personal care.”

**The Chair:** There is a problem in that we have already carried section 30, so we would need unanimous consent to reopen section 30. I would ask for unanimous consent for that. Agreed.

We're now dealing not with subsection 43(1) but subsection 30(2). I would ask for any discussion on the amendment. Hearing none, I am calling for a vote on the amendment. Those in favour?

**Ms. Smith:** That includes our friendly amendment, right? Or have you voted on our friendly—

**Ms. Martel:** No, that's what we're voting on now.

**Ms. Smith:** You're voting on my friendly amendment? Okay.

*Interjection.*

**The Chair:** This is not an amendment. Those much wiser than me, which includes everyone, have indicated that in fact we are not amending. With the change to a different one, it is in effect a new motion.

1500

**Ms. Martel:** So you need us to withdraw everything and start with a new motion under—

**The Chair:** If you would withdraw your motion and then make a motion.

**Ms. Martel:** I'll withdraw my amendment.

**Ms. Smith:** I'll withdraw my amendment. But we have unanimous consent to open 30(2)?

**The Chair:** Right. But now we require a motion.

**Ms. Martel:** Okay, I think I've got the changes.

I move that paragraph 4 of subsection 30(2) of the bill be amended by adding “or the director of nursing and personal care or a registered nurse” after “extended class.”

**The Chair:** Any discussion on that motion? Hearing none, those in favour? Opposed? It's carried.

Shall section 30, as amended, carry? Carried.

We move next to government motion 144.1. There is no page labelled 144.1. When they were putting together all of these amendments, that little one went and hid on us, so it skipped getting branded. It is, in fact, the following page. It has “2” typed at the top, but it is officially government motion 144.1.

**Ms. Smith:** I move that section 43 of the bill be amended by adding the following subsection:

“Admission in a crisis

“(2.1) Where a person is admitted to a secure unit pursuant to section 47 of the Health Care Consent Act, 1996, this section applies, even though the person has already been admitted.”

**The Chair:** Discussion? Hearing none, those in favour? Opposed? It is carried.

We move next to NDP motion 145.

**Ms. Martel:** I move that section 43 of the bill be amended by adding the following subsection:

“Prohibition

“(2.1) If the long-term care home has assessed a secure unit as being required to provide safe care, the placement coordinator shall be prohibited from proceeding with an admission to a non-secure unit.”

This was put forward by OANHSS.

**The Chair:** Discussion?

**Ms. Smith:** We are creating eligibility criteria in the regulations, and there are provisions that allow the home to refuse admission if the home lacks the physical facilities necessary to meet the person's care requirements or if the staff of the home lacks the nursing expertise necessary to meet the person's care requirements. So we think the concerns that are raised here are already covered off.

**Ms. Martel:** Can I just ask a question? Are those in section 36 now?

**Ms. Smith:** Yes. Sorry, they're in—

**Ms. Martel:** Those provisions that you just outlined are in section 36 now, under the regulation-making section? I'm just trying to get at whether you already have that in 36 or whether that is what you propose to do under 36 as you develop regulations.



**Ms. Fox:** Subsection 41(2) of the act provides that we can provide for regulations for the criteria for determining eligibility.

**Ms. Smith:** Subsection 41(2): “The criteria for determining eligibility for long-term care home admission shall be provided for in the regulations.”

**Ms. Martel:** Okay. Given what you’ve said and that those will be taken into account, I’ll withdraw my amendment.

**The Chair:** Motion 145 is withdrawn.

That brings us to government motion 146.

**Ms. Smith:** I move that section 43 of the bill be amended by adding the following subsection:

“Alternative delivery

“(2.2) The rights adviser shall give the written notice required by subclause (2)(a)(i) on behalf of the placement coordinator when requested to do so by the placement coordinator, and the giving of the notice by the rights adviser is sufficient compliance with that subclause.”

**The Chair:** Clarification?

**Ms. Smith:** It’s just so we don’t have to have two visits. You can go, give the notice and give the rights advice right then and there.

**The Chair:** I’ll call the vote. Those in favour? Opposed? Carried.

Government motion 147.

**Ms. Smith:** I move that section 43 of the bill be amended by adding the following subsection:

“Rights adviser to notify placement coordinator

“(2.3) The rights adviser shall notify the placement coordinator if the rights adviser is aware that the incapable person intends to make an application to the Consent and Capacity Board referred to in section 46 of the Health Care Consent Act, 1996 or that another person intends to apply to the Consent and Capacity Board to be appointed as the representative to give or refuse consent to the admission on the incapable person’s behalf.”

What this does is just close the loop, so that if we do have a rights adviser who goes out and gives rights advice, they can report back if the rights advice has been given and what the next step is. So if there is going to be an application before the Consent and Capacity Board or if someone is going to be appointed, at least we know that. It’s just to close the loop.

**The Chair:** Any debate? Hearing none, those in favour? Opposed? The motion is carried.

Government motion 148.

**Ms. Smith:** I move that subsection 43(3) of the bill be amended by striking out “and” at the end of clause (b), by adding “and” at the end of clause (c) and by adding the following clause:

“(d) of any other matters provided for in the regulations.”

This is similar to the previous provision, which would allow us to include in the notice provisions other matters that we determine should be there under regulation.

**The Chair:** Further debate? Those in favour? Opposed? It is carried.

Government motion 149.

**Ms. Smith:** I move that subsections 43(4) and (5) of the bill be struck out and the following substituted:

“When requirements must be satisfied

“(4) The requirements under subsection (2) must be satisfied within the three months prior to the person’s admission to the secure unit.”

This is just rewording to clarify our intent in the admission to the secure unit section.

**The Chair:** I’ll call the vote. Those in favour? Opposed? Carried.

Prior to calling the vote on section 43, we have a notice: The Progressive Conservative Party recommends voting against section 43. Do you wish to speak to it, Mrs. Witmer?

**Mrs. Witmer:** I’m going to withdraw that motion, based on some of the amendments that have been made.

**The Chair:** Thank you. Shall section 43, as amended, carry? It is carried.

That brings us to PC motion 151.

*Interjection.*

**The Chair:** No, it doesn’t. You should have known that I don’t know what I’m doing.

Shall sections 44 to 46, inclusive, carry? They are carried.

I’m sorry about that. Now we’re at PC motion 151.

**Mrs. Witmer:** I move that section 47 of the bill be amended by adding “subject to subsection 42(7)” after “is located.”

This is the controls on the licensee. It requires linking to subsection 42(7)—which is the information that was transferred to the long-term-care home—for some greater clarity, and it closes the loop by requiring the placement coordinator to disclose all the information before the home signs off.

**The Chair:** Ms. Smith?

**Ms. Smith:** I would just note that under subsection (11), “The appropriate placement coordinator may authorize the admission of the applicant to a home only if ... the licensee of the home approves the person’s admission to the home....” There can be no placement without the licensee’s approval, and the approval comes under subsection (7). So I think that including “subject to subsection 42(7)” in this section is in fact redundant and unnecessary.

**Mrs. Witmer:** I would withdraw the amendment, based on the clarification.

**The Chair:** The amendment is withdrawn.

Shall section 47 carry? It is carried.

Moving to section 48, we have PC motion 152.

**1510**

**Mrs. Witmer:** I move that section 48 of the bill be struck out and the following substituted:

“Withholding approval

“48.(1) If the licensee believes there is a risk of harm to the health or well-being of residents of a long-term care home or persons who might be admitted as residents, the licensee may withhold approval of the authorized admission and the matter may be referred to the appeal board for resolution.

"Discharge for harm

"(2) If the licensee believes there is a risk of harm to the health or well-being of residents of a long-term care home or persons who have been admitted as residents as the result of the admission of a resident, the licensee may discharge the resident and the matter may be referred to the appeal board for resolution."

**Ms. Smith:** Under subsection 42(7), a licensee already has the ability to refuse admission if "the home lacks the physical facilities necessary to meet the applicant's care requirements" or "the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements...." We believe that's broad enough for withholding approval and would not want to broaden it any further. With respect to the discharge for harm, there are discharge provisions that are presently dealt with under regulation and we believe that it should continue to be a regulated provision and that we should not be addressing it in legislation.

**The Chair:** I will call the vote. Those in favour? Those opposed? The motion is lost.

Shall section 48 carry? It is carried.

Shall sections 49 to 52, inclusive, carry? Carried.

That brings us to government motion 153.

**Ms. Smith:** I move that clause 53(2)(e) of the bill be struck out and the following substituted:

"(e) providing for exemptions from provisions of this part, subject to any conditions that may be set out in the regulations;

"(e.1) modifying the application of this part for emergencies or other special circumstances specified in the regulations."

This just clarifies what we've already included in clause (e).

**The Chair:** If there's no debate, I will call the vote. Those in favour? Opposed? Carried.

Shall section 53, as amended, carry? Carried.

That moves us to section 54, with PC motion 154.

**Mrs. Witmer:** I move that subsection 54(1) of the bill be amended by adding "where at least one resident requests that a council be established" at the end.

This really just deals with the fact that in order to establish a residents' council you've to have residents, so there obviously needs to be an interest.

**Ms. Smith:** Obviously, we feel that residents' councils are important and need to be mandated in the legislation, not just where one person has requested it. We have residents' councils in almost all of our homes now, and we hope to continue.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? It is lost.

NDP motion 155.

**Ms. Martel:** I move that paragraph 2 of subsection 54(2) of the bill be struck out.

I think it's actually 54(2)2. Ralph is going to correct me if I'm wrong. What I was trying to get at is the section that says, "If a resident is mentally incapable, one of his or her substitute decision-makers." I think we

heard a number of groups that said that really it should just be residents, period. That's what I was trying to do.

**Ms. Smith:** Perhaps, Chair, if I could point Ms. Martel to 157 or 156, both Mrs. Witmer and I are proposing that "only residents of the long-term care home may be members of," and Mrs. Witmer's says "its residents' council" and in ours it's "the residents' council." I'm not sure that too much hinges on either of those, but if you want to withdraw yours, we can deal with the other two.

**Ms. Martel:** Yes, okay.

**Ms. Smith:** And maybe I could just ask Mrs. Witmer if she cares if it's "its" or "the"?

**Mrs. Witmer:** No, it doesn't make any difference.

**Ms. Smith:** Okay, we'd like to take "the," if that's okay. So Mrs. Witmer, if you would withdraw 156.

**Mrs. Witmer:** I would.

**Ms. Smith:** Thank you.

**The Chair:** So 156 is withdrawn.

**Ms. Smith:** Then I move in motion 157 that subsections 54(2) and (3) of the bill be struck out and the following substituted:

"Only residents

"(2) Only residents of the long-term care home may be members of the residents' council."

**The Chair:** If there's no discussion, I will call the vote. Those in favour? Opposed? It is carried.

That brings us to NDP motion number 158.

**Ms. Martel:** I move that subsection 54(3) of the bill be amended by adding the following paragraph:

"3. A person who is employed by the ministry or has a contractual relationship with the minister or with the crown regarding matters for which the minister is responsible."

**Ms. Smith:** On a point of order, Mr. Chair: We just withdrew subsection (3) in my motion. Sorry; maybe I didn't make that clear. I should have said that when we were just talking about language. So if you want to open up 54(2) and (3) again, I'm open to that, but because we're saying "only residents," we took out everybody else, because it would be pretty hard for someone to work for the ministry and be a resident.

**Ms. Martel:** Now I see. I only caught the first part of that. I will withdraw mine.

**The Chair:** That brings us to PC motion number 159.

**Mrs. Witmer:** And obviously, in light of what we did approve, I would withdraw this.

**The Chair:** I will now ask the question. Shall section 54, as amended, carry? Carried.

Moving to section 55, we have PC motion number 160.

**Mrs. Witmer:** I move that paragraph 4 of subsection 55(1) of the bill be amended by adding "in collaboration with the licensee" at the end.

This refers to the fact that obviously anything that is undertaken needs to be done in collaboration with the home.

**Ms. Smith:** We don't actually agree with this amendment. We think that our residents' councils should be



allowed to be independent. While we note that they have to work within the confines of the home or with the home, we think that putting an onus on them to work in collaboration would somewhat tie their hands. We have heard from the residents' councils association that there were some instances where residents' councils were being curtailed from certain activities by the licensee, including opening their own bank account in which to place the funds that they were raising through their own fundraising. So we would hate for this provision to in any way curtail the activities or enthusiasm of our residents' councils, which we hope are contributing to the quality of life of our residents.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? It's lost.

That brings us to government motion number 161.

**Ms. Smith:** I move that subsection 55(1) of the bill be amended by adding the following paragraph:

"6.1 Provide advice and recommendations to the licensee regarding what the residents would like to see done to improve care or the quality of life in the home."

Again, we heard this from a variety of sources, that this would both be helpful for the home and would empower a residents' council to assist in improving the quality of life in the home.

**The Chair:** If there's no discussion, I will call the vote. Those in favour? Opposed? Carried.

NDP motion number 162.

**Ms. Martel:** I move that subsection 55(1) of the bill be amended by adding the following paragraphs:

"10. Advise residents about their rights and responsibilities.

"11. Attempt to resolve disputes between residents.

"12. Provide advice and recommendations to the licensee regarding what residents would like to see done to improve care or quality of life in the home.

"13. Advise the director regarding any concerns that the council has regarding funding and resource allocation in the long-term care home."

I understand that we've dealt with number 12 in the previous amendment, so I'm fine with that, but there are some additional things that I think the residents' council should undertake, and so I've noted those there.

1520

**Ms. Smith:** I note that 55(1), paragraph 1, now requires the residents' council to advise the residents respecting their rights and obligations under the act, so it's already meeting number 10, responsibilities and obligations. On paragraph 11, we actually heard from residents' councils and family councils who did not want to be involved in dispute resolution. We hope that they will be able to assist in attempting to resolve some disputes between the licensee and the home, but I'm not sure that we want them necessarily getting involved in disputes between residents when it's the residents' council. We've addressed paragraph 12 in our own amendment, and with 13, I would just point to subsection (7). The residents' councils now, as the powers are outlined, have the power to report to the director any con-

cerns or recommendations that in the council's opinion ought to be brought to the director's attention, which would include those that are outlined in Ms. Martel's number 13.

**Ms. Martel:** Based on that and that paragraph 12 has been accepted as well, and 13 could be covered under subsection (7), I'll withdraw this motion.

**The Chair:** It is withdrawn.

That brings us to NDP motion number 163.

**Ms. Martel:** I move that subsection 55(2) of the bill be struck out and the following substituted:

"Duty to respond

"(2) If the residents' council has advised the licensee or the director of concerns or recommendations under paragraph 6 or 7 of subsection (1), the licensee or director, as the case may be, shall respond either in writing or in person within 10 days of receiving the advice, and if the response is provided in person, the response shall be noted in the records of the council."

This was put forward by OANHSS, but if you look at 6 and 7, it specifically talks about concerns or recommendations the council has about the operation of the home, and in 7, reporting to the director about concerns and recommendations that ought to be brought to the director's attention, which, if they're going to do that, I assume would be serious enough. So I think the residents' council deserves to have some kind of response in a timely fashion when it is raising serious concerns about the operation of the home or serious concerns to the director.

**Ms. Smith:** We do provide for the residents' council to raise their concerns with the director. However, I would note that a licensee has one residents' council to one home, where the licensee may have many homes, but the administrator would be responding to that residents' council, whereas the director would be required to respond within 10 days to 618 homes, which would be completely impractical and impossible. There are complaints procedures. If it's not a concern that they are raising but in fact a complaint, there's the 1-800 number and there are complaints procedures set out in the enforcement and compliance that do have investigations attached to them, and responses. So I would suggest that this duty to respond on the director's part is far too onerous.

**Ms. Martel:** Can I make two points, Chair? Number one, with respect to the licensee, there isn't any provision at all right now for the licensee to have to respond in any way, shape or form, so I'm concerned about that, if the residents' council takes the time to do that. Secondly, I guess I'm not going to presume that all 600 family councils in the over 600 homes are going to be making a complaint to the director at the same time. I do think that if they make a complaint to the director, if they take that step, which I presume they are going to take seriously when they do it and not for a frivolous matter, there ought to be some kind of written response. I'd be happy to change the days if there is any interest in at least ensuring that the director has to respond.

**Ms. Smith:** I would just point out, when Ms. Martel said there's no obligation on the licensee to respond, in fact, that's the section that you are now looking to amend.

**Ms. Martel:** But there is no timeline within that.

**Ms. Smith:** Yes: "the licensee shall, within 10 days." Oh, maybe that's our amendment that's coming up. Hang on. Why do I have that underlined? No, it's in the proposed bill right now, subsection 55(2): "If the residents' council has advised the licensee of concerns or recommendations under either paragraph 6 or 7 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the residents' council in writing."

**Ms. Martel:** Okay. I apologize, because "the licensee shall," and I think what happened in this amendment was then it had to be both the licensee or the director, because that wasn't included. Whether or not there's any interest in having the director respond in a more formal way, or you just wanted to leave that to the 1-800 line—I just think that if a residents' council takes this step, they are not going to do it for a frivolous matter, and they should get a response.

**Ms. Smith:** We'll see what we can do from an administrative point of view, but I don't think we want to legislate it.

**The Chair:** Shall I call the vote on this?

**Ms. Martel:** Based on what the parliamentary assistant has said, I will withdraw and hope they look at that provision. Thanks.

**The Chair:** Thank you. I will ask the question. Shall section 55, as amended, carry? It is carried.

Moving us to section 56 is government motion number 164.

**Ms. Smith:** I move that subsection 56(2) of the bill be struck out and the following substituted:

"Duties

"(2) In carrying out his or her duties, a residents' council assistant shall take instructions from the residents' council, ensure confidentiality where requested and report to the residents' council."

The reason we've provided "ensure confidentiality" is because we heard from residents' councils that they would like that included.

**Ms. Martel:** Chair, maybe I can speak to this at this time, because the next one would have us voting against the whole section. I think one of the concerns that we heard was that in a number of cases we were talking about staff of the licensee who became the assistant and people's concerns about whether or not that was appropriate. The Registered Nurses' Association of Ontario had put forward an amendment that would have taken that out altogether. That's why I wouldn't really be supporting subsection (2): I think the whole thing should be taken out so that there's no—"attempt" is not the word I'm looking for—opportunity for people to be influenced by a licensee staff member who is attached to the residents' council.

**Ms. Smith:** I would respond by saying that now that we've limited membership on the residents' councils to

just residents, we've empowered them through section 55. We have also, through section 56, given them the ability to accept the assistant that's being given to them, as opposed to assigned. "Every licensee of a long-term care home shall appoint a residents' council assistant who is acceptable to that council to assist the residents' council." So there is an element of accepting that assistant by the council, and in "carrying out his or her duties," we are ensuring that they will respect the wishes of confidentiality, if they are such, by the residents' councils. I think we're putting the protections in place that you're concerned about.

Most of the homes now have their activities coordinator or someone else assigned to the residents' council to assist in, if nothing else, drafting the minutes of their meetings and also liaising with the home to assist with—if in their minutes they're reporting that they don't like the navy beans or something else on the menu, which we heard often, then someone is actually bringing that message back to the administration, if that's what the residents' council asks them to do. I think we have included those protections in the section, and we also are adding further protection by adding this confidentiality component.

**Ms. Martel:** All right. Given that—because my concern was essentially around feeling intimidated by whomever was there—I withdraw that. Well, no: I will vote for this, and I will withdraw the next one.

**The Chair:** Right, that's next. Okay. I'm going to call the vote on motion number 164. Those in favour?

*Interjections.*

**The Chair:** This committee isn't interfering with your discussion, is it?

*Interjections.*

**The Chair:** Okay. Thank you. Those in favour? Those opposed? It is carried.

Motion number 165—

**Ms. Martel:** Chair, this wasn't a specific amendment, so I guess we just move to the vote.

**The Chair:** Okay. I will therefore ask the question. Shall section 56, as amended, carry? Carried.

Moving to section 57, NDP motion number 166.

**Ms. Martel:** I move that subsection 57(1) of the bill be amended by striking out "may" and substituting "shall." I think every long-term-care home should have a family council.

**Ms. Smith:** Actually, on this one, Ms. Martel and I agree, but I don't think that we can mandate volunteerism or participation by individuals who are not necessarily tied to the home. I mean, these are family members of a resident. We have put "may" and we have put provisions in that family members are reminded on a regular basis of the ability to have a family council. I know of at least one home where I've been told that the families are not interested in having a family council because they can all go in and talk to the administrator on their own, and they do regularly.

Yes, I would love to see them in every home. We have supported the family council project with, I believe,



\$240,000 over the last couple of years to assist in developing family councils, a network of them. I know there are some networks that are really taking off and there is a lot of intra-family-council support between homes, so I understand the spirit of it but I don't think we can actually legislate or mandate that we have one.

1530

**Ms. Martel:** All right. Chair, based on that information, I will withdraw that section.

**The Chair:** Withdrawn.

That brings us to government motion 167.

**Ms. Smith:** I move that subsection 57(2) of the bill be amended by striking out "or former resident" wherever it appears.

In this case, we've heard from homes and family councils of their concerns about having people who were not necessarily directly attached to the home being involved, so we're addressing those concerns here.

**The Chair:** I will call the vote. Those in favour? Opposed? Carried.

PC motion 168.

**Mrs. Witmer:** This motion is similar to the NDP motion, plus it bears a little bit of resemblance to the government motion in that it does remove the community, so I will withdraw this and support the government amendment.

**The Chair:** Thank you. That brings us to NDP motion 169.

**Ms. Martel:** I would agree with Mrs. Witmer so I'll withdraw our motion and look to the government's amendment in this regard.

**The Chair:** Motion 169 is withdrawn.

Government motion 170.

**Ms. Smith:** I move that subsection 57(5) of the bill be struck out and the following substituted:

"Right to be a member

"(5) Subject to subsection (6), a family member of a resident or a person of importance to a resident is entitled to be a member of the family council of a long-term care home."

This amendment is here to address some of the concerns that were raised about individuals who'd had no tie to the home being involved in the family council. We wanted to ensure that it was family of a resident or a person of importance. We didn't want to limit it for those who didn't have family but who certainly had people in their lives they wanted involved in the home.

**The Chair:** Any discussion? Those in favour? Opposed? That's carried.

That brings us to PC motion 171.

**Mrs. Witmer:** I move that subsection 57(6) of the bill be amended by adding the following paragraph:

"6. Government officials including a person who is employed by the ministry or has a contractual relationship with the minister or with the crown regarding matters for which the minister is responsible."

Basically this deals with who may not be a member of the family council. We're recommending that these

individuals be listed as not being eligible as well, because obviously they do have a different accountability.

**Ms. Smith:** I'd ask that Mrs. Witmer look at our motion 172 and consider our language. Her language would include "government officials"—any government official. That would mean anyone who works for any level of government: federal, provincial, municipal. That would mean anybody who has anything to do with any ministry, not just the Ministry of Health. I believe her language is incredibly broad.

While we're on the topic, we've introduced, in 172, "a person who is employed by the ministry," which would be the Ministry of Health, "or has a contractual relationship with the minister or with the crown regarding matters for which the minister is responsible and who is involved as part of their responsibilities with long-term care home matters."

We wanted to limit it to ministry officials who deal with long-term care because we think that's legitimate, but we don't think that just because someone lives in Oshawa or Kingston and issues OHIP cards they should be limited from participating in their parent's or their loved one's family council.

**Mrs. Witmer:** Based on that explanation, I am prepared to withdraw my amendment.

**The Chair:** Thank you. Motion 171 is withdrawn, bringing us to government motion 172.

**Ms. Smith:** I move that subsection 57(6) of the bill be amended by adding the following paragraphs:

"6. A person who is employed by the ministry or has a contractual relationship with the minister or with the crown regarding matters for which the minister is responsible and who is involved as part of their responsibilities with long-term care home matters.

"7. Any other person provided for in the regulations."

I've already spoken to why.

**Ms. Martel:** Chair, can I ask a question on this?

**The Chair:** Yes.

**Ms. Martel:** Wouldn't you want to limit it to Ministry of Health?

**Ms. Smith:** "Ministry" is defined in the definition section as Ministry of Health.

**Ms. Martel:** So it's already clear. Sorry.

**The Chair:** I'll call the vote. Those in favour? Opposed? It is carried.

That brings us to government motion 173.

**Ms. Smith:** I move that clause 57(7)(b) of the bill be amended by striking out "quarterly" and substituting "semi-annual".

This is in order to address the concerns that we don't mandate family councils. What we're trying to do is ensure that any family member is aware of the fact that they could have or could establish a family council. While we do acknowledge that perhaps quarterly meetings are a bit excessive, we are amenable to semi-annual meetings.

**The Chair:** No discussion? I will call the vote. Those in favour? Opposed? It's carried.

That brings us to PC motion 174.

**Mrs. Witmer:** In light of the previous amendment by the government, I would withdraw this one.

**The Chair:** That concludes section 57, doesn't it? I will now ask the question. Shall section 57, as amended, carry? It's carried.

Moving to section 58, NDP motion 175.

**Ms. Martel:** We had this discussion earlier, so I guess I'll withdraw it.

**The Chair:** You withdraw? Okay. So I will ask, shall section 58 carry? It is carried.

That moves us to section 59, government motion 176.

**Ms. Smith:** I move that subsection 59(2) of the bill be struck out and the following substituted:

"Duties

"(2) In carrying out his or her duties, a family council assistant shall take instructions from the family council, ensure confidentiality where requested and report to the family council."

This is for the same reasons as we discussed with respect to the residents' council.

**The Chair:** Any discussion? Those in favour? Opposed? Carried.

That concludes section 59. Ms. Martel, do you wish to speak too?

**Ms. Martel:** I do, Chair. These concerns were the same as I raised with respect to the residents' council assistant, so I will accept that we're going to do the best we can to make sure that staff respond to the needs and don't intimidate anybody. I won't vote against it.

**Ms. Smith:** I would just point out that the assistant is accountable to family council again, so that provision is there.

**The Chair:** Shall section 59, as amended, carry? Carried.

Shall section 60 carry? Carried.

That brings us to section 61, and that is NDP motion 178.

**Ms. Martel:** I move that the bill be amended by adding the following section

"Rules re councils

"61. The following apply with respect to the residents' council and the family council:

"1. A licensee that is a corporation shall provide them with minutes of the meetings of the board of directors.

"2. The licensee shall provide them with reports on all expenditures made from the relevant funding envelopes, if requested.

"3. The licensee shall provide them with copies of all inspection and compliance reports.

"4. They have the right to meet with the inspector during the course of the annual inspection."

This provision was put forward by the Registered Nurses' Association of Ontario in their brief to us.

**The Chair:** Ms. Smith?

**Ms. Smith:** I would just ask Ms. Martel to turn to paragraph 58(1)7. The family council of a long-term-care home has the power to do any of the following: "Review," and I would just point out: "i. inspection reports and summaries received under section 146,

"ii. the detailed allocation, by the licensee, of funding under this act and amounts paid by residents,

"iii. the financial statements relating to the home filed with the director under the regulations...."

I think that addresses some of her concerns with respect to 2 and 3. As well, 4 will be addressed; in motion number 284 we're going to deal with that. I think that a great number of these concerns are already dealt with, so we won't be supporting this motion.

**Ms. Martel:** Chair, if I might, the right to meet with an inspector was the one I was most concerned about, so if that's coming on somewhere later, then I'll withdraw this amendment at this time.

**Ms. Smith:** Motion 284.

**Ms. Martel:** Thanks.

**The Chair:** That's withdrawn, and I will ask, shall sections 61 to 63 inclusive carry? Carried.

Section 64 brings us to government motion 179.

**1540**

**Ms. Smith:** I move that section 64 of the bill be struck out and the following substituted:

"Immunity—council members, assistants

"64. No action or other proceeding shall be commenced against a member of a residents' council or family council or a residents' council assistant or family council assistant for anything done or omitted to be done in good faith in the capacity as a member or an assistant."

This is just to mirror the other immunity provisions in the legislation. It's just a rewording to ensure that we have some consistency in how we're drafting immunity.

**The Chair:** If there's no discussion, I will call the vote. Those in favour? Opposed? It is carried.

Shall section 64, as amended, carry? Carried.

Shall sections 65 and 66 carry? Carried.

That brings us to section 67 and PC motion 180.

**Mrs. Witmer:** I move that subsection 67(1) of the bill be struck out and the following substituted:

"Where licensee corporation

"(1) Where a licensee is a corporation, the board of directors of the corporation shall take such measures as the board considers necessary to ensure that the corporation complies with all requirements under this act."

We heard from many of the presenters who were concerned, really, about the language that was used in this part that referred to the duties of directors and officers of a corporation. They believe that changes in language are necessary in order to make it match the language from regulation 965 of the Public Hospitals Act. They were very concerned about the imposition of harsh offence provisions on the directors and officers of long-term-care homes and that they were certainly more harsh than those on directors serving on hospital boards. They believe that this section, combined with section 156, which does not recognize a board's due diligence, and the statutory offence provisions in section 177, substantially increase the duties, responsibilities and liabilities of directors and officers of the corporations operating long-term-care homes. That's from OANHSS. They were concerned that this section makes individual directors and officers



personally liable for ensuring compliance with all the requirements under the act.

The OHA also expressed concern. They feel that there should be consistency with the liability provisions already in other health care legislation. AMO, the Association of Municipalities of Ontario, said this would create unprecedented liability for their councillors. They found it a heavy-handed approach. They said section 67 is a remarkably blunt instrument. They were concerned about the penalties; they were so harsh, went beyond the Public Hospitals Act. We heard from the Catholic Health Association of Ontario and the region of Durham.

I know that the government also has a motion, but there certainly was a tremendous amount of concern regarding this subsection as it is currently worded.

**The Chair:** Any other discussion?

**Ms. Martel:** Chair, if I might just add to that, there are three amendments in a row. Mine is the same as Mrs. Witmer's, and it was put forward because it was the language that was used in the Public Hospitals Act. So I agree with what she said.

**Ms. Smith:** Yes, certainly we've heard the concerns and we've drafted revisions to subsection 67(1), and we've also made substantial revisions to the penalty provisions. Ours is motion 181.

**The Chair:** Okay, I will call the vote.

Those in favour? Opposed? The motion is lost.

That brings us to government motion 181.

**Ms. Smith:** I move that subsection 67(1) of the bill be struck out and the following substituted:

"Duties of directors and officers of a corporation

"67(1) Where a licensee is a corporation, every director and every officer of the corporation shall,

"(a) exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances; and

"(b) take such measures as necessary to ensure that the corporation complies with all requirements under this act."

This incorporates language from the Business Corporations Act, which provides for the care, diligence and skill of a reasonably prudent person as well as some of the language from the Public Hospitals Act.

**The Chair:** Any other debate? I'll call the motion. Those in favour? Opposed? The motion is carried.

That brings us to NDP motion 182.

**Ms. Martel:** Given the amendments that have already been accepted in this area, I will withdraw my motion.

**The Chair:** That brings us to PC motion 183.

**Mrs. Witmer:** I move that section 67 of the bill be amended by adding the following subsection:

"Alternative committee

"(2.1) Nothing in this act prevents the council of a municipality from designating an alternative committee to serve as the board of management or committee of management."

We heard from OANHSS that some municipalities do not operate with a board of management or committee of management but rather designate a standing committee or

the municipal council to assume a governance and oversight role for the home. This amendment simply clarifies that municipalities may designate the committee or structure that will act as a board of management for the long-term-care home, so we are putting this forward on their behalf.

**The Chair:** Discussion?

**Ms. Smith:** Under subsection 123(3), "The regulations may provide for the composition of a board of management and the qualifications and term of office of its members." As well, under 130(3) we have a similar provision with respect to "the composition of a committee of management and the qualifications and term of office of its members." Presently, we have public members on boards of management of our homes. By allowing a municipality to designate an alternative committee, it would be precluding the public membership that is presently appointed by the province, so we believe that our regulations will allow us to determine the composition and the terms of office of its members, and there will be consultations on those regulations.

**The Chair:** Ready for a vote? Those in favour of the motion? Opposed? The motion is lost.

Shall section 67, as amended, carry? That is carried.

We move now to a new section, 67.1. We have NDP motion 184.

**Ms. Martel:** I move that the bill be amended by adding the following section:

"Disclosure of salaries

"67.1 Every executive director of a long-term care home is deemed to be an employee in the public sector for the purposes of the Public Sector Salary Disclosure Act, 1996."

This provision was put forward to us by the Ontario Health Coalition, which said the following: "Currently, salary disclosure legislation applies to homes for the aged. This is unequal. Executive salaries across all long-term-care homes must be made public." The provisions in the salary disclosure act that list when these will be made public include a body that "received funding from the government of Ontario in that year of an amount that is at least equal to" \$1 million, or 10% "of the body's gross revenues for the year if that percentage is \$120,000 or more."

If we require salary disclosure of homes for the aged and directors of, I think that we should also require that for executive directors of nursing homes, both for-profit and not-for-profit.

**Ms. Smith:** I'm unaware of any requirement for the salary disclosure of homes for the aged executive directors. I don't believe that's the case. I didn't hear any submissions around the disclosure of salaries. I think the health coalition was very much, at least in their oral submissions, involved in other issues, including staffing standards. I believe that, as drafted, this section could easily be thwarted by using a term other than "executive director," so I won't be supporting this. I don't actually see the rationale for it.

1550

**Ms. Martel:** A couple of things: The rationale is that if you make a requirement for disclosure by municipal homes for the aged, I think that should be applied to everyone. That was certainly in the written report that we got in our presentation from the Ontario Health Coalition. They did recommend it in their brief. Frankly, we have bodies that are receiving significant public money, and those that do, have folks in charge who also are receiving significant pay for that. I just think it makes sense that when public bodies are receiving public money, if they make over \$100,000, that should be disclosed, just like we require in hospitals and colleges and universities etc.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? It is lost.

Shall sections 68 to 70, inclusive, carry? They are carried.

Section 71: NDP motion 185.

**Ms. Martel:** I move that section 71 of the bill be amended by adding the following subsection:

“Health professions

(2) Every licensee of a long-term care home shall ensure that all of the staff of the home who are members of a regulated health profession are assigned their duties in accordance with the standards and guidelines of their profession.”

This was a provision that was put to us by the Ontario Nurses’ Association.

**Ms. Smith:** I find it perplexing that the Ontario Nurses’ Association would be putting this forward, because the colleges and the regulated health professions acts all provide for what are assigned or acceptable duties for a regulated health professional. If a regulated health professional is concerned about their assigned duties, then they should be reporting that to the college. By placing it in this legislation, it would be creating some conflict with the college. I think it is the responsibility of the college to ensure scope of practice. It’s not the job of the licensees, and I don’t think it’s appropriate to put it in this legislation.

**Ms. Martel:** I think the issue is that the licensee is requesting people to do things that are not within their scope of practice, so then you get into a problem in the home where the licensee is requiring something that may well go against either the scope of practice or obligations that nurses or, frankly, other health care professionals have under their own colleges. The concern would be, then, in that kind of a situation where the balance is clearly tilted in terms of power—one as an employer and one as an employee—that the licensee also has some obligations to make sure that they are not requiring their staff to do things that otherwise they wouldn’t do, either through their scope of practice or because their own college would clearly state that they shouldn’t be doing that kind of thing. That was the reason for putting it forward.

**The Chair:** I will call the question. Those in favour of the motion? Opposed? The motion is lost.

Shall section 71 carry? Carried.

That brings us now to section 72, PC motion 186.

**Mrs. Witmer:** I move that subsection 72(1) of the bill be amended by striking out “temporary, casual or.”

We have a situation here where we do need to ensure that there is continuity of care. I’m not sure what the difference is between temporary and casual. However, I do believe that there is a need for a stable and consistent workforce. I do believe that there’s a need for the same staff to be providing care to residents, so I would recommend that we focus on the use of agency staff.

**Ms. Smith:** If you do believe in the consistency of care and the need for continuity of care, then you would agree that we should be limiting temporary and casual and ensuring that we have more full-time staff in place. That’s why that section of the legislation is there: to ensure that we have more full-time staff in place.

**Mrs. Witmer:** I would wholeheartedly agree with that. However, we’re hearing during the hearings about the difficulties that some of the homes are having in finding individuals who want to work within that climate where they feel so overworked and stressed and they don’t feel that they are allowed to provide care to residents. The government itself is having difficulty in finding sufficient health care providers; we don’t have enough doctors and nurses and some of the other providers. Hospitals are being put in a position where they are hiring individuals who are temporary and casual. But we know that’s not the answer. I think we’re all moving towards full-time staff who will provide consistent care to residents, but I think we also have to recognize in this day and age that it might not always be possible to find that full-time individual.

**Ms. Smith:** And all we’re saying in this legislation is that the long-term-care home ensure that the use of temporary and casual staff is limited. So I think we stand by our provision.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? It is lost.

That brings us to PC motion 187.

**Mrs. Witmer:** I move that the definition of “agency staff” in subsection 72(2) of the bill be amended by striking out “or other third party.”

I think it’s really important that this section not impact negatively on the ability of the LTC home to contract with third party providers of key programs and services. Currently, long-term-care homes are not funded for full-time staff in physiotherapy or dietitian positions, and the contract with the third party is the only way that they can provide some of the core services in an efficient and effective manner. Staff who provide pharmacy services, dietary services, laboratory services, physiotherapy or specialized wound care services are all examples of staff who work at the long-term-care home pursuant to a contract between the licensee and other third party, so they need to be excluded from the definition of “agency staff.”

I need to draw attention to the fact that, unfortunately, in the health system today, whether it’s in the hospitals or whether it’s primary care or whether it’s in long-term-



care homes, there is a need at times to fill some of these vacancies with agency staff.

**Ms. Smith:** I believe I understand what Ms. Witmer is saying, but I think we still need a limitation for "other third party," because another third party could be a sister company that's providing staff while not being considered an agency of staffing per se. There have been other structures that have been created that have created a type of agency relationship, although it's a sister company. We would want to address that through this, because that would just be providing extra payment for staff who should be working in the home.

I don't think that the limitation we're putting on here to include "other third party" in any way limits our ability to use staff like physiotherapists and others who are not hired on a full-time basis in a home. What we've said is that we want to ensure that the use of temporary, casual and agency staff is limited. Of course, if you've only got the requirement for 0.5 of a dietitian, then that would fall within the requirements that are there and would not be caught by this provision.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is lost.

Shall section 72 carry? Carried.

We'll now move to section 73 and government motion 188.

**Ms. Smith:** I move that subsection 73(3) of the bill be struck out and the following substituted:

"When agency staff is hired

"(3) For the purposes of subsection (1), a staff member who is agency staff, as that term is defined in subsection 72(2), is considered to be hired when he or she first works at the home."

This is to address the cases where there's a lag between the time that an agency is brought on and when they come into the home. We want to ensure that they have the—hang on. I've got to figure out what I'm talking about again. It's getting late in the day.

Sorry. It's just to provide consistency so that we know that it's when they first work, not when they're first engaged through the agency. It's nothing more complicated than that.

1600

**The Chair:** I call the vote. Those in favour? Opposed? Carried.

We're still on section 73: NDP motion 189.

**Ms. Martel:** Just a point of order, Chair: I say to the parliamentary assistant, if she wants to give us copies of her cheat sheets, we could follow along with her as we go. It might make it easier.

**Ms. Smith:** I haven't been reading them; that's the problem.

**Ms. Martel:** I know.

I move that section 73 of the bill be amended by adding the following subsection:

"Directors and officers

"(4) This section applies with necessary modification to directors and officers of a licensee that is a corporation."

Section 73 lists that every licensee has to undertake screening measures before they hire staff, and those screening measures "shall include criminal reference checks." I suspect there will be other things they'll have to do because it also talks about regulations. I have no trouble with that at all. What I am interested in is how we deal with some operators who are less than scrupulous, in particular with respect to new licences and what kind of checking we're doing to see who's applying for a licence. The provision is to try and get at the situation where we require this to happen with staff, but we have no requirements with respect to any kind of screening when it comes to directors and officers of licensees that are corporations.

**Ms. Smith:** When we're issuing a licence, we do actually review the potential licensee. As part of that, as you heard earlier today, we looked at some amendments around controlling interests and the definition of "controlling interests," so we do have the ability to look at the history of the corporations and some of their activities. I would love to be a fly on the wall when you appear before AMO and talk to them about the fact that all the councillors who are going to appear on their boards of management are going to have to undergo criminal reference checks.

**Ms. Martel:** Well, why would it be okay for that to happen to staff in those same municipal homes? This is what your requirement means, doesn't it? I say to the parliamentary assistant, your section 73 says that every long-term-care home—I would assume that's municipal homes for the aged—"shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers," and in subsection (2), under "Criminal reference checks," that "the screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age."

If I read this section correctly, we're asking every licensee to do that before they hire staff. So if we're making that a requirement because we think this is a serious issue, I'm not sure why we wouldn't have some kind of similar application to those who are involved in the running of homes as well.

**Ms. Smith:** Normally, the boards of directors of the homes don't have day-to-day involvement with our residents. That's why we put the screening measures in for the staff, who are involved with our residents day to day. We want to ensure their safety and protection, and that's why I've included the screening measures. I don't think that requirement is necessary for directors and officers of a licensee.

**Ms. Martel:** Can I back up, Chair? The amendment says "directors and officers of a licensee that is a corporation," so I'm not sure that that would actually apply to municipal homes for the aged. I don't know if they're considered corporations. Are they?

**Ms. Smith:** Municipalities are corporations.

**Ms. Martel:** Okay. Even in that sense, if they are, I am just a little bit concerned by the discrepancy I see

between what we have around requirements for staff and there being no similar kinds of checks that we should do on people who are involved. So I'll leave it there.

**The Chair:** I'll call the question. Those in favour of the motion? Opposed? The motion is lost.

Shall section 73, as amended, carry? Carried.

Section 74, PC motion 190.

**Mrs. Witmer:** I move that subsection 74(1) of the bill be amended by striking out "provide" and substituting "regularly provide."

We did hear some concerns around the training component within the legislation. We need to remember that many of the training requirements set out in section 74 are not new to the long-term-care homes. In fact, the program manual includes 14 requirements for staff orientation and training. However, the ability of staff to put new skills and knowledge into practice is easily compromised when direct care staff only have 10 minutes to get the residents up, bathed, dressed and to the dining room. No matter how much training you prescribe or provide, it's the total hours of care that each resident receives that will contribute most directly to their quality of care. So if training requirements in this bill and those yet to be specified do not come with additional funding, it's going to be beyond the capacity of the home to provide the training or to sustain the knowledge transfer into day-to-day practice and interaction with the residents. OANHSS acknowledged that it was important for the home to have knowledgeable and well-educated staff and volunteers, but they said that the level of expectation outlined in Bill 140 is unworkable and impractical.

**The Chair:** Ms. Smith?

**Ms. Smith:** If I could direct Mrs. Witmer to 192, the government will be bringing motion 192, limiting even further those who would require the training provided for in section 74. If you could just take a look at that, you may want to withdraw what you have and go with ours.

**Mrs. Witmer:** If you've heeded the arguments that were presented, I'm prepared to withdraw this amendment.

**The Chair:** So it is withdrawn?

**Mrs. Witmer:** Yes.

**The Chair:** That moves us to NDP motion 191.

**Ms. Martel:** I move that subsection 74(1) of the bill be struck out and the following substituted:

"Training

"74(1) Every licensee of a long-term care home shall ensure that all staff, all volunteers and all persons retained by the resident as supplemental privately paid care staff have received training as required by this section."

This came to us as a request by ACE.

**The Chair:** Ms. Smith?

**Ms. Smith:** I don't believe that it's appropriate for us to be legislating a relationship between the supplemental privately paid care staff and a licensee. These staff members are hired by individuals. They have a contract between a family or an individual resident. It's not appropriate for us to be dictating any kind of training. However, I would note that the restraint and abuse pro-

visions do apply to those people who are working within the home because it's abuse by anyone, and the restraint provisions limit any use of restraints to those residents in the care of the home. So I don't think it's appropriate for us to be legislating those private providers that have a contract with a resident or a family member because we are not privy to what their contract provides.

**Ms. Martel:** The only issue I'd raise, then, is that under the current section on training, there is a provision that the long-term-care home's policy promote zero tolerance of abuse and neglect of residents. If you've got someone coming in providing hands-on care, I'm wondering if you wouldn't want to make sure that they have that, since they're coming in to provide direct care in the home and since the licensee still has some requirements about guaranteeing zero tolerance.

**Ms. Smith:** Yes. The requirement is that the licensee shall protect from abuse, and we are posting those requirements, the notice of zero tolerance. Again, I would argue that while we do have the abuse-by-anyone provision in the home, the relationship between these contractors is between the contractor and the family, and it's not our place to be instituting any kind of training.

**The Chair:** I'll call the vote. Those in favour of the amendment? Opposed? The amendment is lost.

That brings us to government motion 192.

**Ms. Smith:** I move that subsection 74(1) of the bill be struck out and the following substituted:

"Training

"74(1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section."

**The Chair:** Any other discussion? Those in favour? Opposed? That's carried.

We're still on section 74. NDP motion 193.

1610

**Ms. Martel:** I move that subsection 74(2) be amended by adding the following paragraph:

"4.1 The protections afforded by section 24."

That is to be included in the list that appears under what has to be provided in terms of training.

**Ms. Smith:** And that's whistle-blower protection. We support that amendment.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? The motion is carried.

That brings us to government motion 194.

**Ms. Smith:** I move that section 74 of the bill be amended:

(a) by striking out the portion of subsection (2) before paragraph 1 and substituting the following:

"(2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:"

(b) by adding the following subsection:

"Exception

"(2.1) Subsection (2) does not apply in the case of emergencies or exceptional and unforeseen circumstances, in which case the training set out in subsection



(2) must be provided within one week of when the person begins performing their responsibilities.”

This is just for ease of drafting. We’ve taken out the exception and placed it at the end to avoid any confusion.

**The Chair:** I will call the vote, then. Those in favour? Opposed? It is carried.

That brings us to government motion 195.

**Ms. Smith:** I move that paragraph 2 of subsection 74(6) of the bill be struck out and the following substituted:

“2. Mental health issues, including caring for persons with dementia.”

We heard from some of our stakeholder groups that “caring for persons with dementia” was not broad enough. They thought we should include “mental health issues,” and we’re happy to do so.

**The Chair:** I will call the vote. Those in favour? Opposed? It is carried.

That brings us to NDP motion 196.

**Ms. Martel:** I move that subsection 74(6) of the bill be amended by adding the following paragraph:

“5.1 Training aimed at achieving the certification level of ‘personal support worker.’”

This is in the training section with respect to direct care staff. I think licensees should be doing what they can to ensure that they can provide the training necessary to their staff so that personal support workers are actually achieving that certification level.

**The Chair:** Ms. Smith?

**Ms. Smith:** I believe it’s inappropriate to be putting the certification level for “personal support worker” in quotes in the legislation. I think under clause 71(b), we have reg-making authority to set out qualifications for different staff. Right now, as far as I know, there are three different levels for personal support workers, three different types of qualifications. I think it would be better set out in regulation what exactly we require for our staff. Again, I just note that earlier today we were discussing the fact that “personal support worker” wasn’t a term used in 1993; it was “health care aide.” Now we do call them personal support workers, but five years from now we may be calling them something different. So I think the qualifications in regulations give us more flexibility and give us the ability to address what qualifications we want.

**Ms. Martel:** Can I just add this? It was clear during the course of the hearings that personal support workers are providing more and more hands-on care, so the attempt was to ensure that we can move to the highest qualifications or provide for the highest level of training possible, given the increased direct care to residents that folks are providing. So if the parliamentary assistant and the government want to take a look at that under the qualifications in the regs, I’ll be happy with that, and I’ll withdraw the amendment.

**The Chair:** Motion 196 is withdrawn, moving us to NDP motion 197.

**Ms. Martel:** I move that section 74 of the bill be amended by adding the following subsection:

“Ministry to incur costs

“(7) The ministry is responsible for any costs incurred by the licensee for training under subsection (6).”

**The Chair:** The amendment is out of order, bringing us to PC motion 198.

**Mrs. Witmer:** I will be withdrawing that motion.

**The Chair:** I will now ask the question. Shall section 74, as amended, carry? It is carried.

We now have a new section 74.1, PC motion 199.

**Mrs. Witmer:** I move that the bill be amended by adding the following section:

“Teaching arrangements

“74.1 The minister shall provide for formal agreements between long-term care homes and universities and community colleges to jointly provide financial support for the training of health care practitioners in the care of the elderly, and the Ministry of Health and Long-Term Care shall provide financial support to enable some long-term care homes to participate in these teaching arrangements through a funding formula outside the formula for resident care.”

**The Chair:** I see you’ve provided guidance for me on this motion.

**Mrs. Witmer:** I did.

**The Chair:** I have to rule it out of order. Thank you. Government motion number 200.

**Ms. Smith:** I move that the bill be amended by adding the following section:

“Training for volunteers

“74.1 Every licensee of a long-term care home shall develop an orientation for volunteers that includes information on,

“(a) the residents’ bill of rights;

“(b) the long-term care home’s mission statement;

“(c) the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents;

“(d) the duty under section 22 to make mandatory reports;

“(e) fire safety and universal infection control practices; and

“(f) any other areas provided for in the regulations.”

We’ve moved away from an intensive training for volunteers to more of an orientation for volunteers. I understand that Ms. Martel may have a couple of friendly amendments to this one. What we’ve tried to do is ensure that there is less paperwork but that our volunteers are receiving the orientation they need with respect to the bill of rights, the mission statement, the zero tolerance for abuse and neglect and their duties to report.

**Ms. Martel:** I’m just trying to think of what those were again, but I think I’ve got it.

**Ms. Smith:** There’s two of them.

**Ms. Martel:** I move a friendly amendment that would have the word “training” for volunteers replaced by the word “orientation” and a new clause (g) at the very bottom that would say “the protections under section 24,” or those “by” section 24—sorry. I’m not sure which word I’m supposed to use there.

**Ms. Smith:** “The protections afforded by section 24” was the one you put in motion 193.

**Ms. Martel:** So let me just confirm, then, Chair, that “training” would be replaced by “orientation” in the title, and a new clause (g) would read, “the protections afforded by section 24.”

**The Chair:** On line (e), the “and” is moved down to line (f).

So we will now debate the amendment to the amendment.

**Ms. Smith:** Call the question.

**Ms. Martel:** I have no comments.

**The Chair:** Shall the amendment to the amendment carry? Carried.

Now, shall new section 74.1 carry? Carried.

Section 75: Before I call for a vote on it, in the order they are in here, is Mrs. Witmer.

**Mrs. Witmer:** In motion 201, I recommend voting against it. We heard from the long-term-care association, OANHSS, and others that in some respects section 75 was impractical and it did not actually achieve its objective. Motion 202 was basically the same thing.

**Ms. Smith:** Yes, 202 is the same. We will be accepting this and voting against it.

1620

**The Chair:** I will therefore ask the question. Shall section 75 carry? Those in favour? Those opposed? The section is lost.

That brings us to PC motion number 203.

**Mrs. Witmer:** I move that clause 76(1)(d) of the bill be amended by striking out “revisions” and substituting “material revisions.”

We heard a lot about more paperwork and micro-management, and there’s no indication here, by including simply the word “revisions,” whether you change a sentence or whether you change a whole section of the admission package, that it must be communicated to a current resident who did receive the first package. If you’re going to have to redo all of the material, it could be costly and in some respects it could be unnecessary. There’s no definition currently of what would be expected when change is necessary.

**Ms. Martel:** I agree with both 203 and 204, because they are the same.

**Ms. Smith:** Exactly. We’re all in agreement.

**Ms. Martel:** We’re in agreement, so that’s great.

**The Chair:** The debate should not be prolonged on this one.

**Mrs. Witmer:** No, because we’re all saying the same thing.

**The Chair:** I would therefore call the vote on 203. Those in favour? Opposed? Carried.

**Ms. Smith:** I withdraw 204.

**The Chair:** Motion number 204 is withdrawn, to no one’s surprise, bringing us to government motion number 205.

**Ms. Smith:** I move that clause 76(2)(g) of the bill be struck out and the following substituted:

“(g) notification of the long-term care home’s policy to minimize the restraining of residents and how a copy of the policy can be obtained.”

Again, in our attempts to limit the paperwork, we determined, and our intention had been, that we give notice of the long-term-care home’s policy to minimize the restraining of residents, but that the entire policy need not be included in the content. But we do provide in that information package how they can obtain a copy of that policy.

**The Chair:** Any discussion? I call the vote. Those in favour? Opposed? It is carried.

Government motion number 206.

**Ms. Smith:** I move that subsection 76(2) of the bill be amended by striking out “and” at the end of clause (p) and by adding the following clause:

“(p.1) an explanation of the protections afforded by section 24; and”

This is again to address Ms. Martel’s concerns about including whistle-blower protection information when we are providing information about the positive duty to report.

**The Chair:** If there’s no debate, those in favour of the motion? Opposed? It is carried.

NDP motion number 207.

**Ms. Martel:** Chair, hang on, because I’m not sure if that has now been dealt with by the addition of “material” revisions or not. Sorry.

I think what I was trying to do in this section was to ensure that revisions didn’t have to be handed out to everybody again, but changes could just be posted, to try to—did yours do that? I’m sorry, Monique.

**Ms. Smith:** It’s okay. We’ve limited it to the requirement that they only have to give material changes, so it will limit it right down. I’m not sure that we have to—what you’d then be saying is that we have to post any revisions.

**Ms. Martel:** Okay. Is “material” defined somewhere, or is that going to be done in regulation?

**Ms. Smith:** I think it’s kind of common parlance, “material.” I’m sure there’s a judge somewhere who has determined what “material” is.

**Ms. Martel:** I’m not actually trying to be facetious. I’m trying to sort out who is going to make the decision, then, about what is material—is the director doing that; is the ministry doing that?—so that you don’t have to send everything out. That’s all.

**Ms. Smith:** The licensee would determine what they see as material, and if there’s a challenge to that, that a change was made that wasn’t provided, then a residents’ council, anyone, could make the complaint, “There was a material change and we didn’t get a notice of the change.” Then it would be determined by the director through the complaints process.

**Ms. Martel:** But it’s each individual licensee that makes that initial determination now?

**Ms. Smith:** Yes. We’re putting the requirement on them that material changes be made available.



**Ms. Martel:** Okay, then, where am I? What I should do, then, is probably withdraw that amendment, I would think. Yes, that's what I'll do, Chair.

**The Chair:** So you're withdrawing it?

**Ms. Martel:** My apologies to everybody.

**The Chair:** I will now ask, shall section 76, as amended, carry? It is carried.

That brings us to PC motion number 208.

**Mrs. Witmer:** I move that subsection 77(3) of the bill be struck out and the following substituted:

"Required information

"(3) The required information for the purposes of subsections (1) and (2) is to be determined by the residents' council and the family council, if any, for the home."

**Ms. Smith:** I believe that the audience for the posting of information is much broader than the residents' council and family council. They, in fact, in a lot of homes have their own boards. This is to provide generation information. With the elimination of section 75—the one we all agreed to eliminate—I think we do need posted information with respect to the residents' bill of rights, the mission statement, the zero tolerance for abuse and neglect and the other things listed in this section. We have in fact made efforts to reduce the paperwork by reducing the requirement on those who need to be trained or given information. We feel that it is imperative that we post the information, and that's why we would not be supporting the amendment proposed by Mrs. Witmer.

**The Chair:** Further debate? If there's none, I will call the vote.

Those in favour of the motion? Those opposed? It is lost.

Government motion number 209.

**Ms. Smith:** I move that clause 77(3)(g) of the bill be struck out and the following substituted:

"(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;"

Again, the same rationale as for the last change.

**The Chair:** Any discussion?

Those in favour? Those opposed? It is carried.

PC motion number 210.

**Mrs. Witmer:** I move that clause 77(3)(k) of the bill be struck out and the following substituted:

"(k) copies of the inspection reports for the long-term care home for the current calendar year, the home's plan and the ministry's response to this plan of action, any orders made by an inspector or director and the status of the results of any appeals;"

**Ms. Smith:** I would ask Mrs. Witmer to take a look at 211, where we are attempting to streamline and also

address some of the concerns. We are including copies of the inspection reports for the last two years, so it's a little bit broader than you have. We also include:

"orders made by an inspector or the director with respect to the ... home ... that have been made in the last two years;

"decisions of the appeal board or Divisional Court that were made ...

"the most recent minutes of the residents' council meetings, with the consent of the residents' council;

"the most recent minutes of the family council meetings ...

"an explanation of the protections afforded under section 24."

We think that these are the important requirements that should be listed, and we think that Mrs. Witmer's clause is too restricted. Also, there's nothing precluding the home from posting its plan if it chooses to do so.

**The Chair:** Further discussion? I will call for a vote.

Those in favour of the motion? Opposed? It is lost.

That brings us to government motion number 211.

**Ms. Smith:** I move that clauses 77(3)(k), (l) and (m) of the bill be struck out and the following substituted:

"(k) copies of the inspection reports from the past two years for the long-term care home;

"(k.1) orders made by an inspector or the director with respect to the long-term care home that are in effect or that have been made in the last two years;

"(k.2) decisions of the appeal board or Divisional Court that were made under this act with respect to the long-term care home within the past two years;

"(l) the most recent minutes of the residents' council meetings, with the consent of the residents' council;

"(m) the most recent minutes of the family council meetings, if any, with the consent of the family council;

"(m.1) an explanation of the protections afforded under section 24; and"

**The Chair:** Any debate?

**Ms. Smith:** I already gave my rationale.

**The Chair:** I will call for the vote. Those in favour? Opposed? It is carried.

I will now ask, shall section 77, as amended, carry? It is carried.

I believe it is probably appropriate, it being now 4:30, to adjourn until tomorrow at 9. I have been very impressed with the committee today. I looked at the type of people around here, and I think we're probably all future presidents of a residents' council somewhere. We will get the benefits of this debate.

The committee is adjourned until 9 o'clock tomorrow.

*The committee adjourned at 1630.*

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**Standing committee on  
social policy**

Long-Term Care  
Homes Act, 2007

**Comité permanent de  
la politique sociale**

Loi de 2007 sur les foyers de  
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STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Wednesday 31 January 2007

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*The committee met at 0904 in committee room 1.*LONG-TERM CARE HOMES ACT, 2007  
LOI DE 2007 SUR LES FOYERS DE SOINS  
DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

**The Vice-Chair (Mr. Khalil Ramal):** Good morning, ladies and gentlemen. Welcome to the second day of clause-by-clause of the standing committee on social policy.

I believe we're now on section 78, motion 212, submitted by the NDP.

**Ms. Shelley Martel (Nickel Belt):** I move that clause 78(1)(b) of the bill be struck out and the following substituted:

"(b) the regulated document has been approved by the ministry."

This was suggested to us by the Advocacy Centre for the Elderly. I myself am not sure what a regulated document is, and I didn't see a definition in the introduction. However, instead of having the compliance certified by a lawyer, my suggestion is that the document or documents have the approval by the ministry and then it can be common across all long-term-care homes. So that was the reason for the submission.

**The Vice-Chair:** Any further debate?

**Ms. Monique M. Smith (Nipissing):** We did hear some feedback on the regulated documents. Certainly, some of the homes do not want to have certification by a lawyer. However, it does give them the flexibility to develop their own documents, but we have the assurance that it complies with the legislation. To have regulated documents—which are defined, actually, in the regulations; there is a provision for that. Let me try to tell you which one. But to have those certified by the ministry would, I think, be considered very prescriptive by our operators.

**Ms. Martel:** Can I just ask what kind of documents we're talking about and why they would need to be certified by a lawyer? I don't have a clear sense of what—some kind of agreement when you're entering a home?

**Ms. Smith:** The regulated documents will be defined in the regulations, and we haven't determined which

ones, but it would be like the admissions agreement and the different types of documents that residents are required to sign on the way in. We want to ensure that they comply with this legislation and with all other legislation. We have heard of certain circumstances, particularly from ACE, where homes are requiring DNRs to be signed upon admission. We don't think that's appropriate, and people aren't being given the proper time or advice to determine what directives they want to give. So we want to ensure that there is no coercion, and that any document they're signing is actually in compliance with our legislation and any other.

**Ms. Martel:** Okay. Two things: It was ACE that put forward the recommendation that I am putting forward now; secondly, I want to be clear—every time there is a new admission in a home, that particular form has to be certified by a lawyer every time, or are you talking about a form that's used all the time that has been certified so—

**Ms. Smith:** A form, yes. What we actually foresee is that the associations would take on that role; once we determine which forms are to be regulated, that broad forms can be developed for the homes by either their association or, if it's a chain, by the chain once they're certified by a lawyer, to comply—

**Ms. Martel:** And it can be used.

**Ms. Smith:** It's not every one; it's a template.

**Ms. Martel:** Okay, thank you. Based on that, Chair, I'll withdraw that motion.

**The Chair (Mr. Ernie Parsons):** That brings us to PC motion 213.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** I move that clause 78(1)(b) of the bill be struck out.

It's the same one. It was to eliminate "the compliance has been certified by a lawyer," but I think, if I hear the parliamentary assistant correctly, it isn't each time that a resident would be admitted to a home; it's once that the documents would have to be certified for each home. Is that right?

**Ms. Smith:** If their template is certified by a lawyer and the template is what they're having a resident sign, then that's fine. If they go off the template, then obviously they've modified it and that particular edition has not been certified by a lawyer. But, yes, our view would be that either the home itself, the associations, the chain, whoever, would come up with some standardized forms. Veering from that would, of course, nullify the certification of the lawyer, but using the template would be fine.

**Mrs. Witmer:** Now, if there were deviation, who would be picking up that cost for the lawyer—the resident or the home?

**Ms. Smith:** I suppose it would come down to who was requiring the deviation.

**Mrs. Witmer:** Okay.

**Ms. Smith:** I don't think we're in a position to make that determination from here. I mean, if a home wants to start changing from the form that it's presenting to the family, then it would be, I think, the home. If it were a family demanding that a change be made and the home wanted to ensure that it was in compliance with this section, it would be up to the home to determine how they wanted to negotiate that.

**Mrs. Witmer:** So it could be possible, if there were a demand from the resident and the family for some sort of a change, that the family could be required to pay this additional cost to a lawyer.

**Ms. Smith:** I think it's a pretty remote possibility. Right now we don't even have the ability to regulate our forms, and our concern is that families are being required to sign things that are inappropriate. That's why this is here. I think your suggestion would be pretty remote.

**Mrs. Witmer:** Okay. Obviously, we don't want a lot more red tape, and we want to be careful as to what additional costs might be incurred for either side, probably. So I'll withdraw that amendment, then.

0910

**The Chair:** Motion 213 is withdrawn, so I will now ask, shall section 78 carry? Carried.

Government motion 214.

**Ms. Smith:** I move that section 79 of the bill be amended by adding the following subsection:

"Preferred accommodation

"(3) Subsection (1) does not apply to an agreement under paragraph 2 of subsection 89(1) except as provided for in the regulations."

This additional reg-making power is to enable the ministry to specify that an agreement between a licensee and a resident to pay the preferred rate is not voidable for a certain period of time.

This is to address some of the concern we heard where someone would sign an agreement to go into preferred and then, because we allow 10 days to void an agreement, they would go in and then void their agreement. So they would kind of queue jump by accepting a preferred bed. This will ensure that if you are accepting a preferred bed, that agreement isn't voidable within 10 days but in fact for a certain period of time—and we're looking at probably a year—to ensure that we don't have that kind of game-playing around waiting lists and getting into homes.

**The Chair:** Any discussion? Hearing none, I will call the vote. Those in favour? Opposed? It is carried.

I will now ask the question. Shall section 79, as amended, carry? It is carried.

Next I will ask, shall section 80 carry? It is carried, bringing us to section 81, PC motion 215.

**Mrs. Witmer:** I would withdraw this motion since another motion that we had introduced was not accepted.

**The Chair:** That's withdrawn.

I will now ask, shall section 81 carry? Carried.

Now moving to section 82, government motion 216.

**Ms. Smith:** I move that section 82 of the bill be struck out and the following substituted:

"Continuous quality improvement

"82. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home."

This is in order to address some of the concerns that were raised by OANHSS and the OMA, both seeking to entrench in the legislation continuous quality improvement. We had "quality management system" but I understand that "continuous quality improvement" is more the state-of-the-art wording, so we wanted to make sure that was addressed here.

**The Chair:** Any discussion? I will call the question. Those in favour of the motion? Opposed? It is carried.

Now I will ask, shall section 82, as amended, carry? It is carried.

Moving to section 83, we have PC motion 217.

**Mrs. Witmer:** I move that subsection 83(1) of the bill be amended by adding "who are capable" after "residents."

This is referring to the satisfaction survey. It says every licensee "shall ensure that, at least once in every year, a survey is taken of the residents and their families." Obviously, all of the families are going to be able to fill out the survey. However, in the case of residents, this acknowledges that all residents might not be able to participate in the survey, so it just defines those who are capable.

**Ms. Smith:** We did look at this very closely, and we're concerned about that particular notion. However, I would just point out to Mrs. Witmer that in our homes—well, depending on whom you listen to—about 60% suffer from dementia and, as you know, dementia can vary with different people. Even though they might be deemed to be legally incapable, some of them can still comment on the food, their accommodation and their home setting. We wanted to keep it as broad as possible so that all residents were given the opportunity to respond and so that we weren't precluding those who may be deemed incapable from actually having their say. So we won't be supporting your motion, although I do recognize why you've introduced it.

**Mrs. Witmer:** What penalties would there be for an operator who obviously was not able to ensure that all the residents were able to fill out the survey? You yourself have acknowledged that there are those who suffer from dementia. I think statistics are indicating to us that the number of those individuals continues to increase. Are there penalties? This is pretty clear. It does say "of the residents," so what about the residents who can't?



**Ms. Smith:** It doesn't say "of every resident." It says the actual obligation is to ensure that "a survey is taken of the residents and their families." So as long as they've taken the survey and they can show that they've provided it to the residents—you can't force people to respond—one way or the other, incapable or not. I would suggest that as long as they've taken the survey, given it to the residents and families, made every good effort to get it out there and collect it, they will have met the obligation.

**Mrs. Witmer:** I will withdraw that motion, with that clarification.

**Ms. Martel:** Can I just ask a question on that? I recognize that in many families it is the family member who is the substitute decision-maker, but sometimes it isn't. Are they going to be permitted to respond to the survey if the resident is not quite capable themselves? Is that opportunity being afforded when you talk about either residents or families?

**Ms. Smith:** The survey is of both. You don't have to be a substitute decision-maker. As a family member, you'll be able to respond.

**Ms. Martel:** But if you've got a resident who doesn't have a family member, who has a substitute decision-maker, the likelihood of them clearly understanding the survey is not so likely, so can the substitute decision-maker do the survey in their place? Is that a possibility or do you want that to happen?

**Ms. Smith:** Yes. If the substitute decision-maker is standing in the place of the resident, there's nothing that would preclude them from doing that.

**Ms. Martel:** But by law, just by saying "resident"—

**Ms. Smith:** "Resident" includes substitute decision-maker. That's understood.

**Ms. Martel:** In law, all the time? That's clearly required.

**Ms. Smith:** You'll note that we didn't put "or substitute decision-maker" in a whole lot of places, because that's kind of understood.

**Ms. Martel:** That's implied. Okay.

**The Chair:** So the motion is withdrawn?

**Mrs. Witmer:** Yes.

**The Chair:** Moving then to NDP motion 218.

**Ms. Martel:** I move that subsection 83(4) of the bill be amended by adding the following clause:

"(a.1) the results of the survey are made available to the union representatives of the workers, or the employee co-chair of the health and safety committee"

The Ontario Nurses' Association made this recommendation. The reason for it was to ensure that if there are issues around how care is being provided, they and their workers know if there is something that they need to be doing so that family members and residents are happier with what is being provided. It allows them the opportunity to know what the problem is and to try to resolve it.

**Ms. Smith:** We don't see the need for this. The satisfaction survey is to look at the operations of the home. If there are improvements that need to be made, the home

will be discussing that with their staff, so they would be receiving the information indirectly, if not directly.

**The Chair:** Any other discussion?

**Ms. Martel:** I guess I don't understand what the problem is. You'll have a survey, you'll have results. The operation of the home, frankly, for the most part, is quite dependent on who is delivering the service and how it's being delivered. I just would think that the front-line staff or their representative would be able to have access to it to know what is being requested, to know if what the licensee is requesting is actually responding to the concerns that were raised. I didn't think it was a big problem. I'll leave it. I mean, I'm not going to withdraw it.

**The Chair:** Okay, I will call the vote. Those in favour of the amendment? Those opposed? The motion is lost.

Government motion 219.

**Ms. Smith:** I move that clause 83(4)(d) of the bill be struck out and the following substituted:

"(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under part IX."

Again, this is addressing some of the concerns around paperwork. As opposed to having to send the documents to the director, we are now stating that they would be kept and reviewed as part of the inspection.

**The Chair:** Any discussion?

**Ms. Smith:** Sorry. This is the documentation around the satisfaction survey.

**The Chair:** If there's no discussion, I will call the vote. Those in favour? Those opposed? The motion is carried.

We're still on section 83, PC motion number 220.

0920

**Mrs. Witmer:** I move that section 83 of the bill be amended by adding the following subsection:

"Results to health quality council"

"(5) The director shall provide annually the results of the survey required by clause (4)(a) to the Ontario Health Quality Council for inclusion in its annual report to the minister."

Really, the introduction of this subsection is to ensure that there is accountability to the public and also that there is increased transparency since the Ontario Health Quality Council, of course, does do an annual survey and does make a report to the minister and to the public.

**The Chair:** Ms. Smith.

**Ms. Smith:** Each home will be doing its own survey. It's not determined that the satisfaction survey would be a regulated document, so there may not be consistency in all of our surveys. As well, given that we just passed the previous motion, the homes will no longer be required to send them to the director but in fact will only have to have them on hand to show to an inspector. There's no real mechanism for amalgamating all of the satisfaction surveys, so logistically it would be very difficult to try to achieve this.

**The Chair:** Any more discussion? I'll call the vote. All those in favour of the motion? Those opposed? The motion is lost, bringing us to PC motion number 221.

**Mrs. Witmer:** I move that section 83 of the bill be amended by adding the following subsection:

“Satisfaction survey

“(6) The ministry shall implement a ... province-wide third party satisfaction survey of residents and families and include the results in the annual report of the Ontario Health Quality Council.”

This does refer to a new survey that would be introduced. Again, it’s an attempt to introduce some—

**The Chair:** Before you speak to it at length—

**Mrs. Witmer:** Do you want to rule it out of order?

**The Chair:** I have to rule it out of order.

**Ms. Smith:** Although you did drop that one word. Nice try.

**The Chair:** I appreciate your “call” perception providing those speaking notes. I’m sorry.

**Mrs. Witmer:** That’s okay.

**The Chair:** Shall section 83, as amended, carry? It is carried.

This brings us to section 84, PC motion 222.

**Mrs. Witmer:** I move that subsection 84(2) of the bill be struck out and the following substituted:

“Requirements of program

“(2) The infection prevention and control program must follow the directives and guidelines established by the ministry’s public health and chief medical officer of health division.”

This recommendation came from both OANHSS and OLTCa, who both had some concerns. The requirement does not reflect current best practices as set out by the province’s provincial infectious diseases advisory council and contained in directives and guidelines intended for the prevention and control of infectious diseases in LTC homes, so this is recommended to be substituted.

**Ms. Smith:** I would differ with the opinion of the OLTCa. In fact, I’ve gone back to our infectious diseases branch, or my gang has, and we’ve confirmed that section 84 as it’s written is the guideline. In order to accept your amendment, we would have to do substantial changes to address who is actually setting out the guidelines.

I would just note that the guide to the control of respiratory infection outbreaks in long-term-care homes, which is the directive from the infectious diseases branch, public health division, states: “Daily surveillance is the most effective way to detect respiratory infections. There are two methods to conduct daily surveillance: active and passive.”

Sullivan continues to detail paths of active surveillance activities. Under “passive surveillance” there is a statement, “Passive surveillance involves looking for infections while providing routine daily care or activities.” So that’s what you’ll find kind of reworded in section 84. We confirmed again last night that section 84 is the appropriate public health directive for infection control and that active and passive surveillance is part of the guidelines.

**Mrs. Witmer:** I heard the parliamentary assistant make reference only to the OLTCa, but I did indicate

that this was a concern of OANHSS as well. They have indicated that they did also believe that the wording in the draft act doesn’t reconcile with good practice in infection prevention and control nor support health transformation and system collaboration. I just want to stress that the concerns did go beyond and did include both, but I appreciate the explanation that’s been given by the parliamentary assistant.

**Ms. Martel:** I understand there would be a guideline that’s similar that homes are to operate by. What happens in the circumstance where you have a specific or more particular outbreak in a home in a particular area? The next recommendation, which was mine, actually referenced local public health authorities to capture that. Is it that you have a guideline that everybody follows generally for daily surveillance? Then, if there’s a specific outbreak, what happens next?

**Ms. Smith:** This is just for the infection prevention and control program for the home, so this is what the homes are required to do day to day. Obviously, if public health issues a directive, then that doesn’t supersede this but it is in addition to the daily maintenance and daily monitoring of infection and disease. We would have a directive from public health or from the ministry’s infectious disease branch advising of further action that needs to be taken, and the homes would be required to do that. This doesn’t preclude that, obviously. This is, day to day, what we expect a home to do on infection control.

**Ms. Martel:** Okay.

**The Chair:** I will call the vote. Those in favour of the motion? Those opposed? The motion is lost, bringing us to NDP motion 223.

**Ms. Martel:** I move that subsection 84(2) of the bill be struck out and the following substituted:

“Directions and guidelines

“(2) The infection prevention and control program shall follow the directions and guidelines established by the chief medical officer of health and local public health authorities.”

I’ve listened to what the parliamentary assistant says, but I’m looking at that particular section, and what I don’t see is where the trigger is for local public health authorities to assume control in the event of an outbreak. I’d just like some clarification around that. The measures that I see here would be daily ones, ongoing. I’m kind of interested in what happens in an—I don’t want to use the word “emergency,” but in an outbreak situation. Are there ministry guidelines around that? Is it implicit in what is here that the local public medical officer of health takes over and their guidelines supersede any ministry guidelines? Do you know what I mean?

**Ms. Smith:** We do have under section 85 emergency plans. Homes are required to develop emergency plans that comply with the regulations and include “measures for dealing with emergencies” and “procedures for evacuating and relocating the residents,” so there is a requirement for them to develop their emergency plans in conjunction with the regulations. I am assuming that the regulations would require them to follow any guidelines



that were issued by public health, but let me just confirm that.

**Ms. Martel:** Yes. I understand emergency, but I'm not really referencing having to move people out of the home.

**Ms. Smith:** I am advised by counsel that public health legislation would supersede, and that's kind of a given. We don't need to address it in our legislation because that is the function of the public health legislation.

**Ms. Martel:** Okay. It was actually more my concern what would happen at the local level in an outbreak, and if other legislation supersedes, then I'm fine with that and I will withdraw this motion.

**The Chair:** Thank you.

Shall section 84 carry? Carried.

Moving to section 85, we have government motion 224.

**Ms. Smith:** I move that subsection 85(2) of the bill be amended by striking out "and volunteers."

We heard a lot about suspected onerous requirements on homes, and we just felt that with respect to the emergency plan as set out in section 85, it was important for our staff to be aware and to be trained. The volunteers obviously would be aware, but we're not expecting that they be trained with respect to the program.

**The Chair:** If there's no discussion, I will call the vote. All those in favour of the motion? Opposed? The motion is carried.

Shall section 85, as amended, carry? Carried.

Shall section 86 carry? Carried.

Moving to section 87, we have government motion 225.

0930

**Ms. Smith:** I move that clause 87(2)(a) of the bill be struck out.

We are moving this regulation-making power to the end of the bill so that any regulations under this particular section would apply to the entire bill, not to just this particular section.

**The Chair:** Those in favour of the motion? Opposed? Carried.

Government motion 226.

**Ms. Smith:** I move that subsection 87(2) of the bill be amended by adding the following clauses:

"(i.1) defining 'temporary' and 'casual' for the purposes of section 72;

"(i.2) providing that the use of other classes of staff are restricted as provided for in section 72, and defining those classes of staff."

Chair, we did hear some questions around what was "temporary" and "casual," so we felt, for the purposes of this particular section of the act, that we should be defining them. Subsection (2) would provide us with the ability to define other classes and to restrict other classes, so that in a situation where someone said, "Well, I'm not a temporary; I'm a walk-in staff," or "I'm a"—fill in the blank—we wanted to be able to address that.

**The Chair:** Discussion? Those in favour of the motion? Opposed? Carried.

Government motion 227.

**Ms. Smith:** I move that clause 87(2)(q) of the bill be amended by striking out "quality management system" and substituting "continuous quality improvement system."

Again, this is to address the concerns of the OMA and others who requested that we include language about CQI.

**The Chair:** Discussion? Those in favour? Opposed? The motion is carried.

Shall section 87, as amended, carry? It is carried.

Moving to section 88, we have PC motion 228.

**Mrs. Witmer:** I move that subsection 88(1) of the bill be struck out and the following substituted:

"Funding

"(1) The minister shall provide funding for a long-term care home consistent with section 1 and sufficient to provide care and services required in part II."

**The Chair:** The motion is out of order.

NDP motion 229.

**Ms. Martel:** I move that subsection 88(1) of the bill be struck out and the following substituted:

"Funding

"(1) The minister shall provide funding to long-term care homes."

**The Chair:** The motion is out of order.

This leads us to NDP motion 230.

**Ms. Martel:** I move that subsection 88(2) of the bill be amended by striking out "may" wherever it appears, and in each case substituting "shall."

This was put forward to us by the Ontario Long Term Care Association. Actually, it might have been OANHSS.

Where it says "Conditions," it says, "(2) The minister may attach conditions to funding provided under subsection (1)...." I guess I would prefer to see "shall." I want to make sure that the money goes where it's intended to go so that, if the government is providing funding for hands-on, front-line care, that's exactly where it goes. I'm not sure how you guarantee that it does that unless you are attaching conditions to how funding that's provided by the government through the Ministry of Health actually goes where it's supposed to go. So that is the reason to change "may" to "shall."

**The Chair:** Ms. Smith.

**Ms. Smith:** You're not going to rule this one out of order?

**Ms. Martel:** It doesn't say "shall fund."

**Ms. Smith:** It says "shall attach conditions to funding."

**The Chair:** I'm thinking.

I've been advised that this motion is fine.

**Ms. Smith:** All right. We won't be supporting it.

**Ms. Martel:** Can I just make this point, Chair? I'm really surprised, all right? It seems to me that if you're going to make an investment in long-term care—particularly in front-line care and hands-on care—you're giving that money to long-term-care homes and you want to be sure that it goes there. The only way you can be sure that

it goes there is to ensure that there are conditions attached to how it's used. I would think that the government would be very interested in doing that: in making the investment and making sure that it gets where it is supposed to go. There's no outlining here about exactly how that funding should be spent or how much—although I'd like to add that, but I recognize that that would be out of order. But it certainly says that if you're going to give any public money, taxpayer money, you'd better make sure that it's going to what you announce it's going to be used for. I really don't see how you can do that and be sure of that and assure the public of that unless you make sure that there are some conditions attached to it: that homes have to spend money for nursing on nurses, that homes have to spend money for PSWs on PSWs, that any increase in the food budget goes to the food budget etc.

**Ms. Smith:** I believe that some of Ms. Martel's concerns are addressed by subsection 3: "The provision of funding under subsection (1) is subject to any other conditions, rules and restrictions that may be provided for in the regulations, including requirements relating to eligibility to receive funding or how funding may be used."

So through our regulation-making power, we're able to address some of those concerns.

**Ms. Martel:** If it was only to be done in regulation, I'm not sure why the section would appear here in the first place. Since it does and since it doesn't appear just by itself in the regulation-making section, did the ministry attach some greater relevance to it by putting it in here? It appears in this section. The only quibble we're having is over the words "shall" or "may."

**Ms. Smith:** The creation of this section allows us to attach particular conditions to particular funding to certain operators, as opposed to a condition that would be attributed just generally to a funding allocation. It's to give us more flexibility in order to put conditions if we need to.

**Ms. Martel:** Can you give us some examples?

**Ms. Smith:** It allows us to put conditions on funding, so that if we were to be providing funding, let's say for a SARS outbreak, to address the homes that had incurred extra costs for all their additional staffing, for changes that they had to make to the home etc., we could target that funding particularly to them. This provision allows for those kinds of conditions to be attached so that we aren't providing that funding to all homes or for all infection control, but for a very detailed and specific situation.

**Ms. Martel:** It appears in a section that talks about the minister providing funding for homes generally, so could it also include, then, money that is supposed to go to enhancing staffing, for example, since it appears in this particular section and there's no reference to an emergency etc.?

**Ms. Smith:** There's no limit to what conditions could be placed.

**Ms. Martel:** I'd certainly like to see some conditions attached, because I'm not sure that money that goes to

long-term-care homes is always going to what the government hopes it is. I think if we're going to improve quality of care, we really want to be sure about that. I'll leave it there.

**The Chair:** I will call the vote, then, on the motion. Those in favour? Opposed? The motion is lost.

PC motion 231.

**Mrs. Witmer:** I move that subsection 88(4) of the bill be amended by adding "subject to the provisions of section 160" at the end.

Of course, we're still dealing here with funding, and this simply would speak to the issue of an appeal. Currently, it appears that it would not be appropriate to allow for an appeal related to a funding set off in one section, section 160, and not allow it in another section, section 88(4). The opinion is that the set-off must be subject to appeal in order that the process is transparent. As you know, if we refer back to section 160, it does set out the provisions relating to appeals.

**Ms. Smith:** In fact, section 160 only relates to appeals of orders, so it would be completely inappropriate to include section 88 under section 160.

**The Chair:** I will call the vote, then. Those in favour of the motion? Opposed? The motion is lost.

NDP motion 232.

0940

**Ms. Martel:** I move that section 88 of the bill be amended by adding the following subsections:

"New requirements impact

"(5) The minister shall commission a third-party cost-benefit analysis of the financial and human resources implications burden that will be placed on homes and their partners in care as a result of new requirements, and, at a minimum, increase operating funding by that amount, and shall fund homes and their partners in care in accordance with this analysis, or whenever there are new standards or mandatory requirements that are placed on homes that prove to add additional financial burden to homes and other parties, and these increases shall take effect at the same time as the new burdens.

"Multi-year funding

"(6) The minister shall develop and implement a multi-year funding commitment for long-term care homes that,

"(a) enables the sustainability of quality and that supports the long-term care homes in effective multi-year planning of care and services; and

"(b) supports regulated and uncontrollable costs.

"Capital renewal program

"(7) The minister shall develop and maintain a funded capital renewal program that will achieve the multi-year capital renewal of the province's long-term care homes and offset the remaining mortgage obligations."

**The Chair:** This motion is out of order.

**Ms. Smith:** But you did a lovely job reading it.

**The Chair:** We move then to PC motion 233.

**Mrs. Witmer:** I move that the bill be amended by adding the following section:



"Capital renewal or retrofit

"88.1 The minister may, out of monies appropriated by the Legislature for the purpose, establish financial assistance for a licensee to assist in defraying capital expenditures incurred or to be incurred by the licensee with respect to the renewal or retrofit of long-term care homes."

**The Chair:** Can I just kind of set that aside for a second? I should have asked a question. Shall section 88 carry? It is carried.

Now, back to motion 233.

**Mrs. Witmer:** Okay. This motion, in many respects, also speaks to the motion introduced by Ms. Martel. The reality is that in this jurisdiction we have more three- and four-bed wards than any other province in Canada. Other Canadian provinces are taking strides to eliminate them, or they have mostly eliminated these type of rooms.

We also know that those individuals who are living in the three- and four-bed wards are paying the same as the individuals who are living in the one- and two-bed wards in the newly designed homes, so this new section would effectively work to eliminate the three- and four-bed ward accommodation in long-term care in the province of Ontario over the next 15 years, and that would at least allow us to catch up to where other Canadian provinces are.

It would also support the capital renewal program that our government undertook when we redeveloped the 16,000 D beds. This would actually deal with the B and C beds.

I think we need to recognize that I did introduce a private member's motion into the Legislature in the fall. It was supported by all three parties and they did agree that there was a need for a capital renewal program for these B and C beds. That was supported by all the parties on November 23, 2006. As a result of that approval by all three political parties, I believe there should be a section in Bill 140 that provides the minister with the ability to flow the capital funding. In addition, a commitment in writing to work with the sector, I think, is absolutely necessary. It provides some certainty to the residents that their homes are going to be renewed. Despite the fact that they're paying the same price as someone in a new home, they obviously don't have the wheelchair accessibility or they don't have the same small dining area, living accommodations, so this motion is intended to eliminate three- and four-bed ward accommodation.

**The Chair:** Ms. Martel?

**Ms. Martel:** Since my motion was ruled out of order, I'm going to speak to this one.

**The Chair:** Would you like an explanation?

**Ms. Martel:** No, I know why. That's okay, Chair. But I did want to get an opportunity to speak to it.

Serious concerns were raised during the course of the public hearings, particularly from homes in smaller rural areas, and I think we need to respond to that. There are significant concerns about licensing and how the licensing is attached to structural compliance. We are operating in an environment where the government has made no

commitment to or made no statement about the possibility of a capital renewal plan to upgrade B and C homes. We heard a lot of that concern in terms of how a lack of announcement in that regard is affecting homes' boards when they go to their banks. We heard very clearly that some already have been told very clearly by their banks that they are going to have difficulty borrowing money, or their interest charges are going to increase.

It seems to me that the temperature around this whole matter could be lowered quite significantly if the government was to indicate through this motion that the possibility for a government-funded retrofit program may exist or may be done, as appears in Mrs. Witmer's motion. We really do need to be moving, for the appropriate care of our residents, to different standards, much improved standards, and the only way, frankly, that's going to be done is if the government is on board with a capital renewal program.

**Ms. Smith:** Subsection 88(1) is broad enough to include any capital renewal program that the ministry may undertake in the future, although I have to say I appreciated hearing Mrs. Witmer's speech on this again.

**Mrs. Witmer:** I guess what struck me when we were participating in the hearings, particularly in the communities outside of the city of Toronto, were the number of small homes that have been open 30, 45, 50 years by a family, obviously by a family who saw a need in a community and built a home, and the family continues to operate the home for the residents in that community. Some of the communities are pretty small, 500 or 1,000. But it has allowed people living in that community to stay in the community. They haven't had to go to a home in a larger urban centre, and we know how important it is to be able to stay within your own local community, to have your family and friends as close by as possible.

I was struck by the fact that some of them said to us, "You know, we put our father here," or mother. "We knew it was a C facility, and we had considered moving them somewhere else, to a facility, a home"—and there's still that confusion of the two words, which I thought was interesting—"but the care they received here was so outstanding."

I just want to make a comment. We really do owe a debt of gratitude to the people who, number one, opened these homes years ago to care for, generally, older, vulnerable people, and who continue to operate the homes, as well as to their dedicated staff. I was really impressed by the level of commitment that the staff spoke about. I hope that sooner as opposed to later we will see a capital renewal plan for these people who have shown their dedication over many years. There will be some certainty. They will be able to get the money from the bank, they'll be able to renew the homes, and there will be a plan of action. I really was impressed by these people in the smaller homes.

**Ms. Martel:** I might just reinforce for the record that there is, of course, a difference between 88(1) and 88.1, the latter being the one we're debating now, Mrs. Witmer's motion. This particular motion specifically

speaks to capital expenditures, so it makes it really clear where government funding could or should go, and I think that's the kind of signal that needs to be sent and the kind of message that people in long-term care need to hear right now, especially in light of the sections that come very soon with respect to fixed licences. So the motion, of course, is much more clear in talking about a capital program that will allow for retrofitting, particularly of B and C homes.

**The Chair:** No other debate?

**Mrs. Witmer:** I'd like a recorded vote, please.

**The Chair:** A recorded vote.

### Ayes

Martel, Witmer.

### Nays

Jeffrey, Leal, Ramal, Rinaldi, Smith.

**The Chair:** The motion is lost.

Moving to section 89, we have government motion 234.

0950

**Ms. Smith:** I move that paragraph 3 of subsection 89(1) of the bill be amended by striking out "determined under the agreement" at the end.

This is just for clarity. The inclusion of "determined under the agreement" actually doesn't make a lot of sense in this section, and what we have provided for is that a reasonable amount be determined. So it should just be removed.

**The Chair:** No discussion? I call the vote. Those in favour? Opposed? Carried.

That moves us to PC motion 235.

**Mrs. Witmer:** I move that subsection 89(3) of the bill be amended by striking out "the resident" and substituting "whoever signed the original agreement."

I guess the argument here in support of this would be that the family members who have control over the finances of the residents do have an obligation and must be made responsible for paying that basic copayment for their family member. Regrettably, to date, I understand that the policies of the ministry have in fact enabled financial abuse by family members and the powers of attorney for finance by not explicitly holding these people accountable for paying the provincial copayment on behalf of the residents. So it's obviously the people in the province of Ontario, the taxpayers, who are suffering, and as it is worded, I understand this continues to foster this type of abuse. It does mean millions of dollars' worth of annual liability for both the government and the operators, because the government pays half of the bad debt. But it's also a betrayal by family members of their loved ones when they renege on their duty to honour the residents' financial obligations. So I believe it is important that we address this issue at this time. I also

understand that bad debt has been increasing at a rate of approximately 20% per year since 2003.

**Ms. Smith:** I would just point out that under motion 237 we are creating a reg-making ability to deal with bad debt, because we too have heard the concerns, and we will be dealing with that through regulations.

**The Chair:** We will call the question. Those in favour of the motion? Opposed? The motion is lost.

I will now ask, shall section 89, as amended, carry? It is carried.

Shall section 90 carry? It is carried.

We move now to section 91 and NDP motion 236.

**Ms. Martel:** I move that section 91 of the bill be amended by adding the following subsection:

"Public

"(4) The director shall make public the reports submitted under subsection (3)."

This whole section deals with non-arm's-length transactions, so it's really clear that the licensee "shall not enter into a non-arm's length transaction...." That's prohibited by the regulations. A licensee shall not enter into such a transaction "without the prior consent of the director if the regulations require such consent...." In the reporting section, which is (3), "Every licensee of a long-term care home shall submit reports to the director ... on every non-arm's length transaction entered into by the licensee."

So the whole flavour of this is that it is not something that the director or the ministry is encouraging, which is fine with me, but it seems to me that if that's the flavour and that's the concern, then those transactions that are allowed, those non-arm's-length transactions, should become public so we can see what it is the director finally agreed to.

This was submitted to us as a proposal by the Ontario Nurses' Association.

**Ms. Smith:** I expected so much more support than just "Fine with me," Shelley.

I think that section 91 does go a long way to address the concerns that have been raised around non-arm's-length transactions. We are setting out what reports will need to be submitted through regulation. We have not determined that yet. There may be some confidentiality issues around various reports that may need to be submitted, so I don't think it would be appropriate to include the amendment that Ms. Martel is suggesting at this time.

**Ms. Martel:** You can cover a lot under "privileged information" if you want to, but let me remind everybody that the whole tone of this section is that the ministry or the director would have concerns around licensees entering into these kinds of transactions. I don't have a problem with that. If the director and the ministry have that kind of concern and are not terribly open to it, it seems to me that on those occasions where the ministry does, that should be a public matter.

**The Chair:** No additional discussion? I will call the vote. Those in favour of the motion? Opposed? The motion is lost.

I will ask, shall section 91 carry? Carried.



That brings us now to section 92. Government motion 237.

**Ms. Smith:** I move that subsection 92(2) of the bill be amended by adding the following clause:

“(c.1) governing the payment of amounts charged by the licensee under section 89.”

This is our provision to deal with bad debts, which we’ve talked about a few times yesterday and again today.

**The Chair:** No other discussion? I will call the vote. Those in favour of the motion? Those opposed? It is carried.

I will ask, shall section 92, as amended, carry? It is carried.

Moving to section 93, we have PC motion 238.

**Mrs. Witmer:** I move that subsection 93(1) of the bill be struck out and the following substituted:

“Licence required

“(1) No person shall establish or maintain a long-term-care home unless under the authority of a licence issued by the director under this act.”

There was some concern expressed. The Ontario Retirement Communities Association did appear before us and was concerned about the impact it might have on retirement homes. I understand that Ms. Smith has indicated that the regulations are going to exempt retirement homes and that there is currently a province-wide consultation taking place to take a look at new legislation which might govern retirement homes. I think we’re looking for clarification here, confirming that retirement homes will be exempted from the requirements of this particular subsection of the bill.

**Ms. Smith:** As Ms. Witmer mentioned, there is a consultation going on right now with respect to retirement homes. I believe it started yesterday in Sudbury. We don’t want to presume the findings of that consultation, but under clause 93(2)(b), the regulation-making authority is there to exclude other premises. The effect of Ms. Witmer’s amendment would be to exclude all municipal homes—which presently are given approvals, not licences—and First Nations homes. Our section 93 as drafted will allow us the flexibility to deal with other situations as they become evident, including retirement homes and any other situations or living arrangements that we may want to address with this regulation.

**Mrs. Witmer:** So you’re saying that there would also be the ability to avoid the impact on, say, assisted living, supportive housing or hospices that all meet the definition as set out in subsection 93(1)?

**Ms. Smith:** In clause 93(2)(b), we have other premises provided for in the regulation, so we can address it if there are certain situations that arise that we think should be excluded.

**Mrs. Witmer:** And you’ll be doing that in regulation.

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**Ms. Smith:** Yes. It gives us the flexibility to not only address what’s happening in the retirement home consultation that’s happening now but also to address situ-

ations that may arise in the future that we can’t actually predict.

**Mrs. Witmer:** So did you say that retirement homes are going to be exempt?

**Ms. Smith:** I said that we couldn’t prejudge what the findings of the review of retirement homes were going to be, but that when their consultation was complete we would be able to address the retirement home issue through clause (b) of subsection (2).

**Mrs. Witmer:** Okay, thank you. I will then withdraw this.

**The Chair:** The motion is withdrawn.

I will ask, shall section 93 carry? Carried.

Section 94: NDP motion 239.

**Ms. Martel:** I move that section 94 of the bill be amended by adding the following subsection:

“First refusal for non-profit

“(2) The minister shall give a right of first refusal to not-for-profit operators or municipal or county governments when establishing new long-term-care beds.”

Section 94 gives the minister the general ability to determine the need for a long-term-care home in a particular area. The section sets out what would be in the public interest, having taken into account a number of things: bed capacity already, other services that are available, etc.

From my perspective, what is in the public interest is ensuring that we have more not-for-profit or municipal or county-operated long-term-care beds in the province of Ontario. That would come as no surprise to anyone in this room. So I think that if the government is interested in also signalling their commitment to not-for-profit long-term care in the province, then the government would be interested as well, in the public interest, in ensuring that when the minister makes a determination for a need for a new long-term-care home or for beds, the ministry is going to not-for-profits or county and municipal governments first to look at their ability to make that offer and to look at their ability to operate those homes, to be licensed or to operate under an approval. This particular amendment was provided to the committee in a submission made by the Registered Nurses Association of Ontario.

**The Chair:** Any discussion?

**Ms. Smith:** Yes. In motion 357, we are indicating our recognition of the not-for-profit sector and commitment to the promotion of the delivery of long-term care. I know we haven’t gotten to that motion yet; it’s 357. It will be in the preamble. I would just point out that, depending on how the program is created, a right of first refusal does not necessarily favour the not-for-profit sector. I note that in previous incarnations, some redevelopment programs have favoured other operators more than not-for-profits, based on how they are issuing licences. So depending on the funding model for a redevelopment program, you can favour, or not, the not-for-profit sector. So I’m not sure that this addition to the legislation would in fact get to the goal that Ms. Martel is setting out.

I'd also note that, in the public interest, in the legislation we look at sector balance. So the minister will be looking at that in determining new licences.

**Ms. Martel:** A couple of points, if I might. If I look at the government's provision in 357, this is an amendment to the preamble which gives a general statement that the government is committed to not-for-profit. I'm talking about a very specific action that will clearly indicate and demonstrate the government's commitment to the not-for-profit, not just a general principle. You can have lots of general principles, but if you give no effect to them, then they also have no meaning. So if the government is committed, as they state they are in the preamble, then the government would want to give effect to that commitment by clearly demonstrating with some action how they are going to demonstrate that commitment. I think that section 94 gives an excellent opportunity for the government to put its money where its mouth is, so to speak, and show very clearly that it is interested in having more not-for-profit and municipal and public homes for the aged in Ontario.

Secondly, with respect to what's going on in the sector, there certainly was a bias by the former Conservative government to award many of the 20,000 new long-term-care homes to the private sector. I disagreed with that. I was very public about that. We know that there are new requests for proposals that are out right now. What I want to make sure is that there is a change in that particular direction and that we change the balance, because from my perspective the balance right now, with Ontario being the province that has the most for-profit beds in the country—I don't think that's a good balance. I don't think that's in the public interest. That means that money that should go into patient care is instead going to the profits of some of those providers, and I don't think that's what we should be doing. So I'm very interested in changing the balance in favour of not-for-profits and municipal homes for the aged.

Thirdly, the parliamentary assistant says that, depending on the funding model that you implement, you can favour or not favour not-for-profits. Then I would say to the government, you should develop a funding model that will favour the not-for-profits. It's in your hands to develop a model of funding, a redevelopment plan, in the same way that the Conservatives did for the D beds. The funding model is entirely in the government's hands. So, as you develop a model for funding, if it is redevelopment or the development of new beds, then you put that model in a way that will favour not-for-profits.

Let me just say again: You can easily resolve the funding issue or who is favoured by developing a model that is in the interests of promoting not-for-profits and municipal homes for the aged. I think it is in the public interest to shift the sector balance, because there is far too much of a percentage of homes in the hands of for-profits now.

Finally, just making the statement that you're committed to not-for-profits in the preamble without having any other section in the bill that actually gives life to that,

gives meaning to that or allows the rubber to hit the road in terms of having some specific change occur makes the preamble and the commitment meaningless. Here's an actual way that the government could demonstrate its commitment, and that is by making sure that section 94 clearly says that when the minister is going to determine a need for new long-term-care beds, the minister is going to go to the not-for-profit and municipal and county governments to see how they can participate first. These are the first people he's going to go see when there are new beds to be permitted out there.

**The Chair:** No further discussion? I will call the vote.

**Ms. Martel:** A recorded vote, please, Chair.

**The Chair:** A recorded vote.

### Ayes

Martel.

### Nays

Jeffrey, Leal, Ramal, Rinaldi, Smith, Witmer.

**The Chair:** The motion is lost.

I will now ask, shall section 94 carry? Carried.

Shall section 95 carry? Carried.

Moving to section 96, we have government motion 240.

**Ms. Smith:** I move that clauses 96(1)(b), (c) and (d) of the bill be struck out and the following substituted:

"(b) the past conduct relating to the operation of a long-term care home or any other matter or business of the following affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity:

"(i) the person,

"(ii) if the person is a corporation, the officers and directors of the corporation and any other person with a controlling interest in the corporation, and

"(iii) if the person with a controlling interest referred to in subclause (ii) is a corporation, the officers and directors of the corporation;

"(c) it has been demonstrated by the person that the person or, where the person is a corporation, its officers and directors and the persons with a controlling interest in it, is competent to operate a long-term care home in a responsible manner in accordance with this act and the regulations and is in a position to furnish or provide the required services;

"(d) the past conduct relating to the operation of a long-term care home or any other matter or business of the following affords reasonable grounds to believe that the home will not be operated in a manner that is prejudicial to the health, safety or welfare of its residents:

"(i) the person,

"(ii) if the person is a corporation, the officers and directors of the corporation and any other person with a controlling interest in the corporation, and



“(iii) if the person with a controlling interest referred to in subclause (ii) is a corporation, the officers and directors of the corporation; and.”

**The Chair:** Do you wish to speak to it?

**Ms. Smith:** This is a continuation on our clarity about controlling interests and ensuring that we have the opportunity to review not only past conduct relating to long-term care but in other areas where we have potential operators who are coming to the sector for the first time.

1010

**The Chair:** Any other discussion? Seeing none, I will call the vote. Those in favour of the motion? Those opposed? The motion is carried.

I will now ask, shall section 96, as amended, carry? Carried.

I will ask, shall sections 97 to 99, inclusive, carry? They are carried.

That brings us now to section 100, PC motion 241.

**Mrs. Witmer:** I move that sections 100 and 101 of the bill be struck out and the following substituted:

“Term

“100(1) A licence shall be issued for a fixed term, specified in the licence, which shall not exceed 25 years.

“New 25-year licence

“(2) A licensee with a replacement licence of 15 years or less, as set out in subsection 180(3), shall receive a new licence for a term of 25 years if there is continued demand for the beds in the area and

“(a) the licensee meets the provincial design standards; or

“(b) the licensee meets the provincial retrofit design standards.

“When commences

“(3) The 25-year licence term commences on the day the licensee receives occupancy approval from the ministry for the rebuilt or retrofit home.

“Replacement licence

“(4) A replacement licence of 20 years or more, as set out in subsection 180(3), shall be renewed at the end of the transitional term for an additional 10-year term, and every 10 years thereafter for a 10-year term, if the licensee can demonstrate the following:

“1. There is continued demand for the beds in the area.

“2. The home does not have ongoing, unresolved compliance issues.

“3. The home is structurally fit to meet the needs of the residents.

“Expiry

“(5) A licence expires at the end of its fixed term if the criteria in subsection (2) or (4) are not met.

“Opportunity to transfer

“(6) Despite subsection (5), if the director is not satisfied that there is a continued demand for beds in the area, the licensee will be given the opportunity to transfer their licence to another area, if there is a need for beds in that area as agreed to by the director, and if clauses (2)(a) and (b) are satisfied.

“Same

“(7) Despite subsection (5), if paragraph 1 of subsection (4) cannot be met to the satisfaction of the di-

rector, the licensee will be given the opportunity to transfer their licence to another area, if there is a need for beds in that area as agreed to by the director, paragraphs 1 and 2 of subsection (4) are satisfied.

“Revocation

“(8) Nothing in this section prevents a licence from being revoked under section 154.

“Reasons

“(9) If the director is not in agreement that the licensee has satisfied the requirements under subsection (2) or (4), the director is required to provide reasons for the decision.

“Appeal

“(10) A licensee whose licence has not been renewed under this section may appeal the director’s decision to the appeal board, and for that purpose, sections 162 to 167 apply with any necessary modifications.”

**The Chair:** I’m going to speak to this bill before you speak, if I could. Procedurally, this motion is in a grey area. It has the effect of amending section 100 and revoking 101 at the same time. Traditionally, we don’t revoke a section but we simply vote against it. However, I’m going to allow it to stand, but I would ask that in the future the sections be dealt with individually. Traditionally, they have been dealt with individually. This one kind of circumvents that, but I will allow it to stand.

**Mrs. Witmer:** Thank you. I do believe this is a very important section. It was probably the one section where there was no consultation, despite the fact that the government and its representatives indicated that there had been consultation with the public and with stakeholders who have an interest in this particular area. This whole issue of fixed licensing terms for long-term-care homes that is going to be based solely on the age and the structure of the building, without taking a look at whether they’re meeting their obligations or anything else—I will tell you that nowhere else in North America do we have this attempt to enshrine that in law. There was no consultation. Nobody asked either the not-for-profits and the people who run the municipal homes or the people who have the private homes whether or not this was appropriate.

An amendment was provided that attempted to meet the government halfway—a compromise—and I’ve just put that amendment forward. It was drafted by the Ontario Long Term Care Association. They didn’t come out and say, “We don’t want fixed licence terms”; they acknowledged that if this is what the government chose to do, they understood. But they were prepared to put forward this type of compromise to at least make sure there was some certainty in the sector and that if a licence is going to be revoked, it is going to be for just cause.

Also, this moves us forward, hopefully. If the government is prepared to indicate that they are going to be involved in a capital renewal plan, we could actually eliminate the three- and four-bed ward accommodation in Ontario and provide some reasonable and appropriate certainty to the licensees, the residents and the families.

Instead, if the bill continues to move forward as it is written, Ontario will be the first jurisdiction in Canada,

likely in North America, to enshrine in law a fixed licence term for long-term-care homes that is based solely on the age and structure of the building—nothing to do with compliance or whether that home is meeting the needs of its residents; nothing to do with performance. Other jurisdictions and the law we currently have focus licence renewal on the performance of the home in meeting the care and service requirements as set out in legislation and regulations.

We have a scheme here that, if not amended, is going to create uncertainty. We heard people step up to the plate time and time and time again and say that if they had this short term, if there wasn't any guarantee of a renewal plan for the C and B beds, they wouldn't have the money to renew their own homes; they aren't going to be able to borrow it from the bank because nobody's going to lend you money if there's this much uncertainty about the future of the home. And people in those small rural communities I talked about before could all lose their homes. I hope it's not the intent of the government to close down all those little homes in small communities across the province and force all the people to go to the larger urban centres. I'll tell you, there is a fear out there, when you travel to the small towns and villages, that they're going to be forced—for example, everybody who lives close to London is going to have to go there because the homes in Clinton, Exeter, Hensall and Zurich are all going to be closed down.

So the current scheme creates uncertainty for the licensee, the staff, the families, the residents. The act puts a deadline on the operating licence, and it provides no answer to the question of what happens next.

Even the new homes are going to have their licences expire 25 years from the date they first admitted their residents, which in many cases was 2001. Only the new homes opening after this bill passes are actually going to get the 25-year licence.

1020

So three years from the licence expiry date, which could be 10 years or 12 years, whatever, under the current plan the ministry can do anything it wants to. They can take away the licence. They can close the home. They can move the beds—you know, from Zurich to London. They can move the residents to another community. They could ask the operator to rebuild to the new design standards to keep their licence, knowing full well that this is totally impossible from a financial point of view without the government providing some capital funding. They could ask the operator to invest hundreds of thousands or even millions of dollars to do upgrades to their home that are not going to address the core issues of resident comfort, dignity and safety by continuing to have residents live in three- and four-bed wards. They can decide to renew the licence with no changes because at that time it might be the politically expedient thing to do, or the government may decide that that particular community does not deserve a new home.

I guess the problem currently is that the ministry doesn't have to give a reason for its decision. I know

there is going to be some change made to the time frame. It is very frightening. I think we also have to take into consideration that we have a shortage of long-term-care beds in the province, and that shortage is simply going to increase as the number of older people increases. The provincial average occupancy today is well over 98%. And do you know what? We probably aren't going to be moving beds around because they're probably going to be required everywhere.

I am very disappointed that the government didn't try to reach a compromise and provide some stability, security and certainty to the people in the homes in this province, our oldest and frailest residents, to ensure that the homes in those communities are going to continue to be there; that there will be a capital renewal plan; that they're going to make sure they meet the modern standards of comfort and dignity. I guess under the current licensing scheme there is no commitment to the funding that is required to begin the structural renewal of older homes. That was funding that we provided to the 16,000 D beds in homes. The government has already recognized the need for capital funding by including the \$10.35 to the cost of construction for the new homes that they're building in places like Kingston and Hastings county etc. So I don't know how this licensing scheme could be appropriate, because I think that not only Kingston and Hastings county and London—where they've recently made some announcements—but all communities across Ontario deserve the same commitment so that they can continue to not only have a long-term-care home in their community but that their home provides the residents with access to the same physical comforts as the government is now going to provide to residents who are going to be living in these new homes or the ones that were recently rebuilt.

Also, we're going to continue to ask people to pay the same fees; however, half of them receive noticeably less for their money than others. This is a concern not just for the private sector; it's a concern for the charitable and the not-for-profit homes. They're concerned that their donors will be more reluctant to continue their support if this does not change. They are concerned about their ability to obtain financing on reasonable terms. They feel it will be further weakened by the limited licensing scheme and lack of funding commitment to rebuild the older homes. If you combine this with the fact that this act limits the value of the home by restricting transfer to only another not-for-profit operator currently, this just magnifies the issue.

Probably the people who are most put at risk by the current licensing scheme are the small charitable homes and those small homes that we heard from in rural Ontario. They might have to exit the sector; the home will no longer be available in that small town or that community.

Let's remember: The number of seniors aged 75 and over is going to increase by 49% by 2016. That is less than 10 years away. That is also the time that 300-plus long-term-care homes will have their operating licences



expire. So there is huge uncertainty, because they don't know what the government is going to do, and it can be pulled for any reason. So the cost to borrow money also is going to increase because the risks to the lenders have changed dramatically. There is less money today to provide services that are paid for out of the accommodation envelope, such as repairs, maintenance, house-keeping, laundry, dietary services, continuing education. The fact is that if the government is not going to provide some certainty that a home will receive a licence beyond a fixed term, the banks are not going to loan the money to the operators for upgrades. In the event that they do, they are going to pay a high, high interest rate that's going to be taken out of the money that should be available for the care of the residents. In the meantime, if the government doesn't make changes, instead of the residents getting a better environment in which to live, these homes are simply going to fall into a state of disrepair.

I would urge the government—I know you haven't tried to look at making changes to this section; I know you've had no discussions with people who are concerned about this issue—remember the pleas that we heard from those small operators out there who just don't have the money. They don't have the money to make the changes. They'd love to do the capital renewal, but there's no money available. We could lose those homes. Those homes could be lost at a time when the number of seniors, as I've just said, is going to increase by 49%. So I would ask you to give very serious consideration to making changes and accepting this particular amendment.

**The Chair:** Other debate?

**Ms. Smith:** Great; we get to do it all over again.

Well, I of course have to respond to what Ms. Witmer had to say, if only to put on the record the facts as opposed to the fearmongering that has been shared yet again, which actually I thought you were above.

We are, of course, aware of the demographics, as your government would have been aware of the demographics when you instituted your redevelopment program in the late 1990s. I would note that in the auditor's report of 2002, he noted, "In our 1995 annual report, we noted that, although it was aware of significant growth projected for the population aged 65 and over, the ministry did not have a strategy for dealing with the anticipated increase in demand for long-term-care beds. We also noted that it did not have a systematic plan to determine where beds were most needed and to eliminate the wide variations in bed supply to make it equitable throughout the province."

I believe that 2002 was under your mandate as a government, and you did very little to address that concern. You did, in fact, introduce a redevelopment plan, which, as we have heard many times from a variety of people, including the OLTCa in their response to our white paper—they noted that the method utilized in the allocation of the 20,000 new beds has led to significant overbedding in some areas and a lack of sufficient beds in other areas. Certainly, we heard from a variety of people

about the lack of beds in certain areas. What we have tried to do through our legislation and through our licensing scheme is to provide the government with tools to allow for planning of the system.

To your point that we did no consultation, I would just note that in fact we have consulted time and again since 2003 and 2004. Leading up to my report, Commitment to Care, we certainly spoke to a variety of stakeholder groups and over 100 individuals and groups. In 2004, we put out our Future Directions for Legislation Governing Long-Term Care Homes. To that, we received 754 written responses. We had 35 stakeholder group meetings, and we received briefs from 57 stakeholder groups. We also did public meetings in seven locations across the province. Within the future directions for legislation governing long-term care, there were questions dealing with licences, and we did specifically ask the questions around licensing and what people would like to see in that scheme.

**1030**

I would note that the OLTCa, in its submission to our white paper, requested the elimination of the requirement for public notice and public meetings relating to the decrease in bed capacity or movement of beds to another area in the province. I would note that in your amendment, which you're putting forward as motion 241, you have in fact eliminated any public consultation whatsoever, which I find so very interesting when you talk about the fact that (a) you feel there has been no consultation, and (b) that you feel that the smaller communities are not being heard. In fact, you've eliminated any ability for small communities to be heard in your motion.

As well, I would note in your motion you're allowing for the transfer of beds in two different areas, under subsection (6) and subsection (7), and again with no public consultation. In our legislation, where we're talking about licensing, where we're talking about the changes of bed allocations, we do in fact have a duty to consult the public. I would note in subsection 101(4), in subsection 103(4) and in section 104 a whole scheme for public consultation which you would have us completely lose.

You talked about uncertainty in the system. I would say that part of that is attributable to your legacy and where you've overbuilt and underbuilt. I would note, however, that the present uncertainty that you spoke about was not played out when we spoke to the operator of Omni, in southeastern Ontario, who spoke about the fact that his chain is being sold and he has had no problems with that sale based on the legislation that's out there. As well, we heard about Central Care Corp., which is presently being sold. Again, we've heard no concerns around uncertainty in this sector.

You spoke about the needs and concerns in smaller communities and the fearmongering that you and others have raised about closing homes in small communities. I would just note that that goes counter to our transformation agenda and the McGuinty government's commitment to care close to people's homes through the creation of the local health integrated networks, through

our family health teams and through investments in various small communities across the province. We've shown a huge commitment to care closer to home. I know that in my community we've seen the results of that commitment.

I would note that I've visited dozens of homes over the last three years. I am certainly well aware of the smaller communities' need for homes. We are well aware of the demographics, and I think the suggestion that we would be closing homes in small communities is absolutely ridiculous, knowing full well that we have growth in the numbers of our seniors across the province, and we are committed to ensuring that those seniors receive the care they need in their communities.

What we've done through our scheme, as set out in the legislation, is provide us with the tools that we feel are necessary in order to address the needs across the province, and we will continue to do that.

**The Chair:** Further discussion?

**Mrs. Witmer:** I do appreciate the comments. There's only one thing that I would have to say I did not appreciate. I don't think that we have to personalize. Do you know what? We're putting arguments forward on behalf of the individuals whose presentations we listened to over the course of the five days. If there's any fear-mongering happening, it's because people did indicate to us their concern. I can also tell you from personal experience that it was some of the people in the homes in the communities throughout Ontario who came to me and said, "We hear we might lose our home and our home won't be here."

I'm telling you what I've heard. I am not fearmongering. People are concerned. There is no reason that needs to be given for the transfer of any home or the closing of any home. There doesn't have to be anything. The ministry just has carte blanche to do whatever they want to do, even if it were based on certain criteria, but there are no criteria here. You need to look at the facts; the ministry needs to look at the facts. The truth is, you can refer to the reports of 2002 and you can refer to the reports of 2004. Currently in the province of Ontario we are no longer underbedded. The provincial average occupancy is well over 98%, and you would be hard-pressed as a ministry to find areas in this province that are hugely overbedded. In fact, we're having the exact opposite problem. We are seeing surgeries in Kingston cancelled. Sudbury is having problems. It doesn't matter where you go in the province of Ontario, the lack of long-term-care beds or alternative-level beds is at a point today where surgeries are being cancelled and emergency rooms are backed up. There are huge problems in the system, so I would encourage the people who are taking a look at this to stop saying we're overbedded. We're not overbedded. The average occupancy today is 98%.

Also, we know that the number of seniors in this province is going to increase by 49% by the year 2016. If you would even compromise to the point where there would be criteria involved in closing down a home, it would provide some certainty, but there is no certainty

here. Currently, the ministry simply doesn't have to give a reason for their decision. That's what is creating the uncertainty throughout the province of Ontario. The fearmongering—I mean, the reality is that an older person is very fearful. That's why people can so easily take advantage of them. It was people who approached us. I got calls and I was really quite surprised. I think the reason I got them is because I'd been the Minister of Health and Long-Term Care at one time. But I had no reason to be concerned until I got a few phone calls, and they weren't from operators; they were from innocent people who were concerned about their family member or they were concerned about their own little home in some community not being there when they would need it. I just would urge the government to be more understanding and accommodating. As I say, it's never been my intention to fearmonger and I did not appreciate that comment. I have always tried to put on the record what I hear from other people. My job here is to bring to your attention, whether or not you want to hear it, what I'm hearing from the public in Ontario.

**The Chair:** Ms. Smith.

**Ms. Smith:** I appreciate that. I did not mean to personalize it, so I apologize, Mrs. Witmer. I do note, however, that when you started talking about what you were hearing, that people were saying, "I hear my home is closing," that is the fearmongering that I'm getting at and that has been started by the operators. The forgotten campaign by the OLTCA I think is reprehensible. We have heard from the residents' council project that they have expressed grave concerns and would not participate in that because they felt that it was unacceptable. So I just note that for the record.

I don't want to engage in a whole long debate again, but I did want to note that you said there's no obligation for consultation. In fact, with our licensing scheme, three years prior to the end of a licence we do have a duty to consult the public as well as to engage in discussion with the operator, and I would note that under subsection 101(4). On the occupancy rates, we are still seeing homes in the GTA in particular that have occupancy rates in the 70% and 80% range, which would lead us to believe that we still do have some areas that are overbedded. We certainly are all in agreement that there are areas in the province that are underbedded, no doubt about that. I just wanted to clarify the point around section 101 and what I was getting at in my "fearmongering" comments.

**The Chair:** We'll call the vote. Those in favour of the motion? Those opposed? The motion is lost.

Before calling the vote on section 100, Ms. Martel, do you wish to speak to it?

**Ms. Martel:** Yes, I do, Mr. Chair. I am recommending that we vote against section 100 and, tied to that, section 180. Section 100 says, "A licence shall be issued for a fixed term, specified in the licence, which shall not exceed 25 years." Section 180 in the bill then sets out the different categories of beds and the fixed terms, in terms of years, that are attached to each of those. People will see, as they've gone forward in this package, that the two are tied together, and I suggest that we vote against both.



1040

There are a couple of reasons for this. There were certainly a couple of ways to deal with this issue. One was to put forward an amendment, which Mrs. Witmer has done, to try to fix in some way, shape or form what the government has proposed and change the number of years etc. I appreciate that perspective and I appreciate her putting it forward.

The second was the way that I have proposed. It is to vote against the section entirely and not have fixed terms on licences. This is what I want to speak to in terms of my reasoning for that.

First, the government through this particular section proposes a fixed licence that's tied to structural compliance or tied to the age and structure of the home. We did hear during the course of the public hearings concern about that. I'm not talking about concern raised by residents which may or may not have been provoked or prompted by others. I'm talking about some direct questions that were raised with operators, particularly operators of small homes in rural areas, and also operators of not-for-profit homes. Those are the folks I want to focus on, because the reality is that the chains will always be able to manage, no matter what. Whether it's licences, whether it's funding etc., the chains will always be able to make their way. I'm not worried about the chain operations when I look at this particular section.

We did clearly hear from small operators, we did clearly hear from not-for-profits, that already institutions that they have a financial relationship with are raising concerns about what is proposed in this bill. The nature of the concern, which is that these homes are now going to be a risk, is also leading those very same financial institutions to suggest that because of the risk, they would be increasing their borrowing rates or putting other terms and conditions on mortgages or new mortgages. That, of course, will increase the risk of borrowing, and the only folks who are going to benefit from that are the banks. I'm not interested in that kind of scheme at all. I am looking for a way where that is not going to happen. We can argue about whether or not the position being put forward by the financial institutions is legitimate. The reality is that we did hear from people who said that that was already clearly happening, and I think we have to acknowledge that and respond to that.

Secondly, I look at why the government is putting in fixed licences. I can only assume the government wants to do this because they are trying to ensure that there is redevelopment of B and C beds. I'd ask the government to consider a more historical perspective around redevelopment. If you look at the experience of the renewal of the D beds, 14,000 out of the 16,000 did rebuild within the time frame that was set out by the former government, without any licence tied to structure, so without any kind of licence that said, "You have to be done in this time." So 14,000 out of 16,000, from my perspective, is quite a significant number of operators who complied. Granted, they complied because there was a capital funding project that was available, but I think

that the government, in whatever it does, is going to have to acknowledge that and also have to respond. Without any kind of capital program here, much like the Tories had in the last two governments, I don't think we're going to be able to see that redevelopment. There will just be any number of smaller homes—not-for-profit, for-profit—that will not be able to manage the financial costs associated with that.

This is why I was happy, when I got my original package of amendments, to see that the government, I thought, was moving a bit down the road to recognize that assistance with capital costs was going to be required. In the amendment, which was pulled—and I want to make it clear that it was pulled when we started on Monday—that was in our package, around section 125, it clearly said,

"Assistance with capital costs

"(3) Without restricting the generality of section 88"—we've dealt with section 88 already. That is a section that talks about funding of homes. It says, "Without restricting the generality of section 88 to assist in defraying the costs of establishing a new municipal home or the alteration, renovation or addition to or extension of an existing municipal home, the minister may direct payment out of the money appropriated by the Legislature for the purpose of an amount determined in accordance with the regulations and based on the proportion of the cost that is allocated to the unorganized parts of the territorial district in which the home is established."

Now, I want to say again very clearly: It was pulled. However, I was happy when I saw it because I thought there was clear recognition here that we're going to have to have capital assistance from the government. This case only referred to municipal homes, but that was a start, in my opinion—we're going to have to have that. I regret that it was pulled. I don't know the reason for that, but I certainly thought there was a recognition that the government had heard what people had to say about the absolute necessity of having a capital funding program. So I hope the government is going to reconsider that.

From my perspective, it was clear—and it's the smaller folks whom I'm speaking for—that there are concerns that financial institutions, rightly or wrongly, are speaking to homes they are having a funding relationship with to suggest that they are going to be a risk, to suggest that they are going to change the terms and conditions and to suggest that there is going to be an increased cost to borrowing, which is to nobody's benefit, as I said, except the bank's.

Secondly, I look at the D beds and I see, without any kind of implementation of a fixed licence tied to structure, that the overwhelming majority of homes did make the renovations that were necessary. They did that, of course, with a government capital renewal program, which is going to be essential for B and C redevelopment.

The final point I want to make is, if the government has specific concerns about specific homes, they could deal with those under section 99, which talks about con-

ditions of the licence. Subsection 99(1) says, "A licence is subject to the conditions, if any, that are provided for in the regulations." So, as I read that, I see that if the government has some specific concerns about specific homes that they think won't comply, even in the environment where there is a capital redevelopment program, then deal with those specific homes by attaching something to their own licence. Don't cover the waterfront with everybody in the way that it's being covered with respect to the fixed licence.

My final point is that I think it was clear with the D beds and the government's capital program that homes and operators did step up to the plate and did make the structural changes that were required. I think that if the government had a redevelopment program, the same scenario would follow; those operators with B and C beds would also step up to the plate. You're not going to have 35,000 B and C beds re-created overnight into two-bed wards—I understand that—but the D beds weren't altered overnight either. Clearly, any kind of structural plan, financial plan to aid in the restructuring of these beds will have to be carried out over time and the government could hopefully fix a set number of beds that it would like to see renovated, redone or upgraded each year.

I come down on the side of not having a fixed licence with a fixed term, because I think to tie a licence to the age and structure of a home is just going to cause all kinds of grief for smaller for-profit and not-for-profit homes in a way that they don't need to have those problems caused. If the government was out there with a capital program, the experience that we have seen—and it's a most recent experience—is that operators will comply, will come forward, and the work will be done.

I would encourage the government to reconsider the approach that it's taking and work with the current structure, which allows for a one-year licence, and if and when there is a problem, to use section 99, which would allow you to set conditions for specific or particular homes that don't want to comply with redevelopment, even with government funding attached.

**The Chair:** I'll call the vote. Shall section 100 carry? It is carried.

Moving to section 101, we have PC motion 243.

1050

**Mrs. Witmer:** I would withdraw that motion, based on another motion, 244, by the government.

**The Chair:** Thank you. That brings us to government motion 244.

**Ms. Smith:** I move that subsection 101(3) of the bill be struck out.

**The Chair:** Any discussion? I'll call the vote. Those in favour? Opposed? It is carried.

That brings us to NDP motion 245.

**Ms. Martel:** I move that section 101 of the bill be struck out and the following substituted:

"Reasons

"101 The director shall provide reasons for deciding whether or not to issue a new licence."

This motion followed on what I wanted to do in section 100, so the current section 101 would have been replaced entirely in most of that section with the new 101. That relates specifically to what is currently in the bill around subsection 101(5), which says, "The director is not required to provide reasons for deciding whether or not to issue a new licence." I think the director should always have to provide reasons for deciding whether or not to issue a new licence. I think that's in the public interest and I think that should be a public matter, and that the director should be obliged to do so.

**The Chair:** Any discussion? Ms. Smith.

**Ms. Smith:** I just note that under subsection (4), public consultation is required. The government cannot act arbitrarily, so there's always the opportunity for judicial review, but there's also nothing precluding the director from giving reasons through this legislation.

**Ms. Martel:** Chair, if I might, if I look at subsection 101(4), the obligation on the director is to consult the public. It's not an obligation to provide reasons why the licence was issued or not issued. So I think it's a bizarre circumstance that we would put an onus on the director to consult with the public about new licences, which I absolutely agree with, but then not provide a reason to the same public who participated in those consultations about whether or not that licence was issued and, if it wasn't, why not. I just think, sensibly, to follow the duty to consult also gives rise to a duty to advise people of your decision. I don't understand what the dilemma is about making public those reasons. It is in the public interest. If you want to have the public participate in the process, then they should at least know the reasons why, if something is denied.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is lost.

I will now ask, shall section 101, as amended, carry? It is carried.

To section 102. We have PC motion 246.

**Mrs. Witmer:** I move that subsection 102(3) of the bill be amended:

(a) by striking out "occupied or" in the portion before clause (a); and

(b) by striking out "unoccupied and" in clause (a).

I think this is really just a matter of some clarity.

**Ms. Smith:** Chair, could I ask if Ms. Witmer would look at 247, which is our motion.

**Mrs. Witmer:** You know, I did look at 247—

**Ms. Smith:** It is a question of clarity, and we've tried to redraft it so it's clearer. I would just point out that in your motion we could interpret it to read that an occupied bed is not available, which in fact is not available because it's occupied. That's not what we want. We want to look at beds that are unoccupied and unavailable. That's why in motion 247 we've made that, I think, a little clearer. So if you would be willing to look at our language, I think it actually clarifies a little bit better.

**Mrs. Witmer:** I do appreciate that explanation and I would withdraw my amendment.



**The Chair:** Thank you. Motion 246 is withdrawn, bringing us to government motion 247.

**Mr. Jeff Leal (Peterborough):** I move that subsection 102(3) of the bill be struck out and the following substituted:

“Reduction of licensed beds

“(3) If beds are unoccupied and unavailable for occupancy for 14 consecutive days or more, and the licensee did not obtain written permission from the director for them not to be available for occupancy, the director may, by order served on the licensee,

“(a) amend the licence to reduce the number of beds allowed under the licence by the number of unoccupied and unavailable beds; or

“(b) impose any conditions on the licence that are provided for in the regulations.”

**The Chair:** Thank you. Does anyone wish to speak to this motion?

**Ms. Smith:** Same comments as on the previous motion.

**The Chair:** I will call the vote. Those in favour? Opposed? It is carried.

I will ask the question: Shall section 102, as amended, carry? It is carried.

We now move to a new section 102.1, NDP motion 248.

**Ms. Martel:** Thank you, Chair. I move that the bill be amended by adding the following section:

“Certain appeals

“102.1 Despite anything else in this act, the following are parties to an appeal under subsection 96(4) or 102(4), and have the same rights as the other parties:

“1. Family members of residents.

“2. Residents’ councils.

“3. Unions representing long-term care home staff.”

This particular section references the ability of a licensee whose licence has been amended or had conditions imposed on it to appeal that director’s order to the appeal board. I’m suggesting that other parties who would have an interest in that because they have family members living in the home or because they work in the home should also be able to participate in that process. This proposal was made by the Ontario Nurses’ Association.

**The Chair:** Debate?

**Ms. Smith:** Yes. First of all, I would note that it’s 96(3) that is the appeal. And secondly, I don’t recall hearing from any residents’ council or family council members whatsoever about wanting to participate in the appeal process, so I will not be supporting this motion.

**Ms. Martel:** Outside of the fact that you didn’t hear from anyone—even though OANHSS submitted it—do you have a reason beyond that that says that people didn’t mention it in their presentation so it’s not a worthy amendment?

**Ms. Smith:** The issue is between the government and the licensee. There are provisions for public input around these decisions. I don’t see that the residents or family

members, or union representatives for that matter, would have a role to play in an appeal.

**Ms. Martel:** If I might: An issue around a long-term-care home is never just the business of the director and the licensee. Under this particular section, the director can make an order to amend or impose conditions on a licensee and on that licence. I think that’s an issue that a number of people would have an interest in and a right to be involved in. These matters aren’t just between the government and the licensee, especially if the condition or the order has some kind of an impact on folks in the home.

**The Chair:** I’ll call the vote. Those in favour of the motion? Those opposed? The motion is lost.

Section 103, government motion 249.

**Ms. Smith:** I move that subsection 103(7) of the bill be amended by striking out “subsection (2)” and substituting “subsection (6).”

This is just to clarify consistency in drafting.

**The Chair:** No debate? I will call the question: Those in favour? Opposed? It is carried, moving us to PC motion 250.

**Mrs. Witmer:** I move that subsection 103(9) of the bill be struck out.

This is the one, of course, that currently is worded to say that a non-profit entity may not transfer a licence or beds to a for-profit entity, except in limited circumstances provided for in the regulations. Actually, we did hear from the not-for-profits. They felt that this did put them at somewhat of a disadvantage with regard to sales and they thought it might affect the value of their homes. Already today the minister does have discretion over the balance between not-for-profit and for-profit long-term-care homes in clause 95(b). And as we know, all licence transfers today must also be approved by the director under section 103. I put this forward on behalf of those individuals who felt that they may be somewhat disadvantaged.

1100

**Ms. Smith:** I would just note that we also did hear from a variety of presenters, including the health coalition in some of our communities, who wanted us actually to take out “except in the limited circumstances provided for in the regulations” and wanted to even strengthen this. So while we did hear some who wanted it removed, we heard others who wanted it strengthened. We certainly recognize the need to protect the not-for-profit sector and we think that it’s appropriate to keep this in the legislation.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? The motion is lost.

Shall section 103, as amended, carry? Carried.

Moving to section 104, we have NDP motion 251.

**Ms. Martel:** I move that subsection 104(1) of the bill be amended by striking out “or” at the end of clause (d) and by adding the following clause:

“(d.1) approving a management contract under section 109; or.”

Right now under section 104, it lists out the situations under which the director would consult the public, so it includes a number of circumstances that can arise where the director shall consult the public. I'd like to add to that that the director shall also consult the public when the director is making a decision to enter into a management contract, and that appears under section 109. So it's one more circumstance or situation where the director would have to consult with the public before the approval or the signing-off of that management contract occurs.

**Ms. Smith:** I believe that would be adding yet another what has been described as "onerous" process in the legislation. We are providing ourselves with the ability to review management contracts. We are also providing the director with the ability to withdraw approval, and we are requiring our homes to provide us with notice of material change. So there's much more oversight into the management contract question than we've had in the past, and I believe that adding a public consultation on it would be too onerous for the home and the ministry.

**Ms. Martel:** If I might, Chair, the government is setting out in 104 at least five other areas where the public has to be consulted, so if you want to talk about onerous, then maybe you want to talk about why there are already five and I want to add one more. I just think—

**Ms. Smith:** Just to address that—

**Ms. Martel:** —that's kind of bizarre.

**The Chair:** Ms. Martel has the floor.

**Ms. Martel:** In the cases that we heard from a lot of the licensees, the issue was the impact on the caseload or the workload of the licensee. I'm talking about the obligation of the director, and I think that's a completely different matter. The director is already having a responsibility under subsection (4) to consult the public before,

"(a) issuing a licence for a new long-term care home...;

"(b) undertaking to issue a licence under section 98;

"(c) deciding whether or not to issue a new licence under section 101;

"(d) transferring a licence, or beds under a licence, under section 103; or

"(e) amending a licence to increase the number of beds under subsection 112(3)."

So asking the director, because that's who the onus falls on, to consult before a management contract is approved I don't think is a huge increased burden for the director.

**Ms. Smith:** I would just point out that the director's obligation to consult in section 104 is all around licensing. There is certainly generally some public concern and interest in licensing. We didn't hear from anyone from the public on their concern about management contracts.

We are entrenching in legislation the government's obligation to consult around licensing. I think I made that point earlier. We think it's very important to get that input, but I don't see the need to get that input around management contracts.

**The Chair:** I will call the vote. Those in favour of the motion? Those opposed? The motion is lost.

I will now ask, shall section 104 carry? Carried.

Shall section 105 carry? Carried.

We now move to section 106, government motion 252.

**Ms. Smith:** I move that section 106 of the bill be struck out and the following substituted:

"Notice

"106(1) A licensee that is a corporation shall notify the director in writing within 15 days of any change in the officers or directors of the corporation.

"Same

"(2) A licensee shall immediately notify the director in writing if the licensee has reason to believe that a person has gained a controlling interest in the licensee.

"Same, management contract

"(3) Where a long-term care home is managed by a person under a contract under section 109, the licensee of the home shall immediately notify the director in writing if the licensee has reason to believe that anything mentioned in subsection (1) or (2) has occurred with respect to the person."

This is around our clarifying the change-of-control question and ensuring that we have the appropriate ability to review any changes in control.

**The Chair:** Any discussion? I will call the vote. Those in favour? Opposed? It is carried.

I will now ask, shall section 106, as amended, carry? Carried.

We move to section 107: government motion 253.

**Ms. Smith:** Again, this is around capturing the different corporate structures.

I move that section 107 of the bill be struck out and the following substituted:

"Gaining controlling interest

"107(1) A person that by any method gains a controlling interest in a licensee shall obtain the approval of the director.

"Director's approval

"(2) The approval by the director is subject to any restrictions by the minister under section 95 and subject to section 96 as those sections would apply with respect to the licensee if the person had already gained a controlling interest in the licensee.

"Attachment of conditions

"(3) The director may attach conditions to an approval.

"Regulations may provide for timing, process

"(4) The regulations may provide for when the approval of the director must be obtained and for the process for obtaining such approval."

Again, we're looking at capturing different corporate structures in order to be able to review them.

**The Chair:** No discussion? Those in favour of the motion? Opposed? It is carried.

I will now call the vote. Shall section 107, as amended, carry? Carried.



We now come to section 108. Are there any comments? I will call the vote. Shall section 108 carry?

**Ms. Smith:** No.

**The Chair:** The section is not carried.

That moves us to section 109 and NDP motion 255.

**Ms. Martel:** This referenced a section around the director consulting the public that the government has already voted down, so I will withdraw it.

**The Chair:** It is withdrawn.

That moves us to PC motion 256.

**Mrs. Witmer:** I would withdraw that.

**The Chair:** PC motion 257.

**Mrs. Witmer:** I would withdraw that.

**The Chair:** We move to government motion 258.

**Ms. Smith:** Chair, could we just have a moment, please?

Sorry. I was planning on withdrawing 258, because I thought I was going to support 257. Mrs. Witmer just threw me off by withdrawing.

**Mrs. Witmer:** You've got it in your 258.

**Ms. Smith:** Yes, exactly.

I move that subsection 109(6) of the bill be amended by adding "materially" after "amended."

**The Chair:** Any discussion? Sensing some agreement, I will call the vote. Those in favour? Opposed? It is carried.

Shall section 109, as amended, carry? It is carried.

Moving now to section 110, NDP motion 259.

**Ms. Martel:** I move that subsection 110(1) of the bill be amended by striking out "The director" and substituting "Following public consultation, the director." The rest of that would read "may issue a temporary licence."

Section 104 talked about the obligation of public consultation by the director around licences, as was pointed out by Ms. Smith. So I think that in the case of temporary licences and the issuing of them, the director shall also have an obligation to consult the public. That's what this requirement would do. It was put forward by the Ontario Nurses' Association.

**1110**

**Ms. Smith:** We would just note that there are a number of different types of licences. Temporary licences are licences that can be issued up to five years. They're non-renewable. This is in fact to allow for the introduction of interim beds. The government has the ability, with the issuing of temporary licences, to move more quickly to address demand issues. Again I note that they are five-year, non-renewable. If something permanent was needed, then we would be looking at the section 104 requirements for consultation.

I think that public consultation on this particular provision would slow down the process and remove some of the flexibility that we are creating here to address issues that are emerging in communities.

**The Chair:** I will call the vote. Those in favour of 259? Those opposed? The motion is lost.

Government motion 260.

**Ms. Smith:** I move that paragraph 3 of subsection 110(2) of the bill be struck out and the following substituted:

"3. No interest in a temporary licence, including a beneficial interest, may be transferred."

This is just to clarify that these are temporary licences and that there is no intrinsic value with them.

**The Chair:** I'll call the vote. Those in favour? Opposed? Carried.

I will ask, shall section 110, as amended, carry? It is carried.

That brings us to a new section, 110.1, government motion 261.

**Ms. Smith:** I move that the bill be amended by adding the following section:

"Temporary emergency licences

"110.1(1) In circumstances provided for in the regulations where there is a temporary emergency, the director may issue a temporary emergency licence,

"(a) authorizing premises to be used as a long-term care home on a temporary basis; or

"(b) authorizing temporary additional beds at a long-term care home.

"Rules for temporary emergency licence

"(2) The following apply with respect to a temporary emergency licence:

"1. The licence may be revoked by the director at any time on the giving of the notice provided for in the licence, as well as being revocable under section 154.

"2. The licence may be issued for a term of no more than 60 days, and may not be renewed or reissued.

"3. No interest in a temporary emergency licence, including a beneficial interest, may be transferred.

"Provisions that do not apply

"(3) The following provisions do not apply with respect to a temporary emergency licence:

"1. Section 94.

"2. Section 95.

"3. Section 101.

"4. Section 103.

"5. Section 104.

"6. Any other provisions provided for in the regulations."

These are for the creation of emergency beds in the case of a fire, in the case of SARS, where we need to act quickly. It would only be for a maximum of 60 days. If there was a requirement for anything further, then we have our temporary beds, which we just addressed previously. This is to allow us the flexibility to be able to set up beds in emergency situations and not necessarily fulfill all of the obligations of having a residents' council and family council etc.

**The Chair:** I will call the vote, then. Those in favour of the motion? Those opposed? The motion is carried.

Section 111: We have government motion 262.

**Ms. Smith:** I move that section 111 of the bill be struck out and the following substituted:

"Short term authorizations

"111. In the circumstances provided for in the regulations, the director may authorize temporary additional

beds at a long-term care home for a single period of not more than 30 consecutive days.”

This is our kind of final, absolute emergency. This is in a situation where we have someone in the community who is in a crisis situation and there is no one to care for them. We need to develop one bed in a home in order to address that crisis. It could happen within a 24-hour period and we need the flexibility to be able to do that. Again, I note that it's for not more than 30 days and it's a case-by-case situation.

**The Chair:** I will call the vote. Those in favour? Those opposed? It is carried.

I will now ask, shall section 111, as amended, carry? It is carried.

Moving to section 112, government motion 263.

**Ms. Smith:** I move that section 112 of the bill be amended by adding the following subsection:

“Extension in certain cases

“(2.1) Despite clause (2)(b), a licence may be amended under this section to extend its term where there is,

“(a) a substantial renovation of the home; or

“(b) a significant addition of beds to the home.”

This is to allow us some flexibility where a home has a partial redevelopment or does a retrofit or is awarded new beds under a new RFP and is adding those beds to an existing structure. We want to be able to address those types of concerns as they arise.

**The Chair:** We'll call the vote. Those in favour? Opposed? It is carried.

Government motion 264.

**Ms. Smith:** I move that subsection 112(3) of the bill be amended by adding “or extend the term under subsection (2.1)” after “number of beds.”

It's a follow-up to our previous, and it allows for amendments only in very limited circumstances.

**The Chair:** I'm calling the vote. Those in favour? Opposed? Carried.

I will now ask, shall section 112, as amended, carry? It is carried.

Moving to section 113, we have NDP motion 265.

**Ms. Martel:** I move that section 113 of the bill be struck out and the following substituted:

“First refusal for non-profits

“113(1) A competitive process may be applied after not-for-profit providers are given the first right of refusal for new licences.

“Restrictions on competitive process

“(2) The competitive process shall not be operated in such a manner as to disadvantage the establishment of non-profit or municipal long-term care homes or have a detrimental effect on the number of non-profit and municipal long-term care homes relative to for-profit homes in the area and in Ontario.”

This follows in line with comments I made earlier around the minister's ability to determine whether new beds should be opened. At that point under section 94 I said it was in the public interest to open new not-for-profit and municipal homes, and that if the government was really committed to the not-for-profit and municipal

sector, this was a concrete way to demonstrate that again in this section, because it talks about the issuing of licences. I recognize that it speaks more to the issue of approvals for long-term-care beds, but nonetheless, if the government is committed to this particular sector, not-for-profits and municipals, this is a very concrete way in the legislation to demonstrate that so that in fact those two groups—not-for-profits and municipal homes—would be given the right of first refusal under any competitive process, in fact would be given that before a competitive process would even begin.

**The Chair:** Discussion?

**Ms. Smith:** Thank you, Chair. Just to reiterate—I think we've already had this discussion—in the preamble, in our motion, we will be dealing with the not-for-profit question. Under clause 95(b), the minister is required to review the effect of any issuing of a licence on the balance between non-profit and for-profit homes. As well, we are restricting the ability of not-for-profits to transfer to for-profits under subsection 103(9).

**The Chair:** I'll call the vote. Those in favour? Those opposed? The motion is lost.

I will now ask, shall section 113 carry? Carried.

Moving to section 114, government motion 266.

**Ms. Smith:** I move that section 114 of the bill be struck out and the following substituted:

“No appeal

“114(1) Decisions of the minister under this part in respect of sections 94 and 95 are within the sole discretion of the minister and are not subject to an appeal.

“Same, director

“(2) Decisions of the director under this part with respect to the following are within the sole discretion of the director and are not subject to an appeal:

“1. A decision to issue or not to issue a licence or an undertaking to issue a licence, including the giving of a notice under clause 101(1)(a) that no new licence will be issued.

“2. A decision with respect to the term of a licence, number of beds, or any other condition of a licence.”

I would just note for clarity that there are still judicial review provisions and that we will be clarifying that through our motion number 319, but the judicial review provisions exist under section 176, and this section does not preclude judicial review.

**1120**

**Mrs. Witmer:** We have a subsequent motion that seeks to delete the entire section 114 of the bill. The concern we have is that currently those decisions are made solely by the minister and the director. There is no need to give any reason for those decisions, and that doesn't allow for any public scrutiny or any transparency in policy-making or decision-making. That was the reason we had asked for the removal of that section.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? The motion is carried.

Prior to my calling the vote on section 114, I would ask Mrs. Witmer if she wishes to speak.



**Mrs. Witmer:** I've just spoken to why we were asking that section 114 be voted against.

**The Chair:** Shall section 114, as amended, carry? It is carried.

We are moving to section 115 and government motion 268.

**Ms. Smith:** I move that subsection 115(2) of the bill be amended by adding the following clause:

"(0.a) defining 'nursing care' for the purposes of subsection 93(1)."

This deals with the first section around where licences are required. It deals with which types of—I use the word advisedly—"facilities" we would be determining to be long-term-care homes or not. We want to be able to address what type of nursing care provided in a home would preclude them from being included in long-term care or include them in long-term care.

**The Chair:** I will call the vote. Those in favour? Opposed? Carried.

We are moving to government motion 269.

**Ms. Smith:** I move that clause 115(2)(c) of the bill be struck out and the following substituted:

"(c) governing the process of consulting the public for the purposes of section 104 and governing public meetings under that section, including the notices for such meetings."

Here we are simply broadening the regulation-making power to allow more detail about how our public meetings and public consultations would be held.

**The Chair:** I'll call the vote. Those in favour? Opposed? It is carried.

Shall section 115, as amended, carry? It is carried.

We are moving to section 116 and government motion 270.

**Ms. Smith:** I move that the definition of "northern municipality" in section 116 of the bill be struck out and the following substituted:

"'northern municipality' means a municipality in a territorial district as set out in regulations under the Territorial Division Act, 2002, but does not include the district municipality of Muskoka; ('municipalité du nord')"

This is to add some clarity. We've transferred the obligations with respect to municipal homes from previous legislation, and in doing that transfer there was some ambiguity around what we were referring to as northern municipalities, so this clarifies that.

**The Chair:** I'll call the vote. Those in favour? Opposed? Carried.

Shall section 116, as amended, carry? It is carried.

Section 117 and NDP motion 271.

**Ms. Martel:** I move that subsection 117(1) of the bill be struck out and the following substituted:

"Municipal homes

"(1) Every municipality not in a territorial district shall establish and maintain one or more municipal homes and shall be supported by the ministry through provincial subsidies to do so."

**The Chair:** This motion is out of order.

I will now ask, shall section 117 carry? It is carried.

Shall sections 118 to 126, inclusive, carry?

**Ms. Smith:** We've withdrawn 272.

**Ms. Martel:** It was a good one, though.

**The Chair:** You didn't think I made an error, did you?

*Interjections.*

**The Chair:** So I will ask again, shall sections 118 to 126 carry? Carried.

That moves us to section 127, government motion 273.

**Ms. Smith:** I move that subsection 127(6) of the bill be struck out.

This is no longer needed, given that there are other provisions in the act that address this issue.

**The Chair:** Those in favour of the motion? Opposed? It is carried.

Shall section 127, as amended, carry? Carried.

Bringing us to section 128, NDP motion 274.

**Ms. Martel:** I move that subsection 128(1) of the bill be amended by adding "which approval shall be supported by a commitment for operating and capital funding" at the end.

**The Chair:** The motion is out of order.

That brings us, still on section 128, to PC motion 275.

**Mrs. Witmer:** I move that section 128 of the bill be amended by adding the following subsections:

"Funding commitment

"(1.1) The minister's approval of the municipal or joint home shall be supported by a commitment for operating and capital funding.

"Legal names

"(1.2) The legal names of municipal homes and their bed allocations shall be included in the regulations, or in a schedule to the regulations indicating that each home named has ownership of or a legal right to the bed allocation as listed."

**The Chair:** That is a money bill.

**Mrs. Witmer:** Right.

**The Chair:** It is out of order.

**Mrs. Witmer:** Right. I was waiting for you to tell me that.

**The Chair:** There was no look of surprise on your face. I'm sorry I was late getting to it.

**Mrs. Witmer:** We just want to get that message about funding across.

**The Chair:** I will now ask, shall section 128 carry? Carried.

That brings us to section 129, government motion 276.

**Mr. Khalil Ramal (London-Fanshawe):** I move that subsection 129(3) of the bill be amended by adding the following paragraph:

"10. Section 115 (Regulations)."

**Ms. Smith:** This is just to ensure that our regulations under section 115 apply to municipal and First Nations homes, which are homes that receive approvals.

**The Chair:** If there is no discussion, I will call the vote. Those in favour? Opposed? Carried.

Still on section 129, government motion 277.

**Mrs. Linda Jeffrey (Brampton Centre):** I move that subsection 129(5) of the bill be amended by striking out “modifications apply” in the portion before paragraph 1, and substituting “modification applies” and by striking out paragraph 2.

**The Chair:** Any discussion?

**Ms. Smith:** By striking out paragraph 2, we are actually allowing public consultations.

**The Chair:** I will call the vote. Those in favour? Opposed? It is carried.

Shall section 129, as amended, carry? It is carried.

Shall sections 130 to 132, inclusive, carry? Carried.

Bringing us to section 133, government motion 278.

**Mr. Leal:** I move that section 133 of the bill be amended by adding the following subsection:

“Appeal

“(2) A decision of the director under subsection (1) may be appealed to the appeal board, and sections 159 and 161 to 168 apply to such an appeal with necessary modifications.”

**Ms. Smith:** Mr. Chair, just to speak to that: We heard from our municipal homes some concern around a director’s ability to make orders for renovations. They were requesting that we include an appeal process, and we have therefore included that appeal process through this motion.

1130

**The Chair:** No discussion? I will call the vote. Those in favour? Those opposed? It is carried on a 2 to 0 vote.

I will now ask, shall section 133, as amended, carry? It is carried.

Shall sections 134 to 137 carry? They are carried.

We now have a new section, section 137.1. NDP motion 279.

**Ms. Martel:** I move that the bill be amended by adding the following section:

“Worker’s rights protected

“137.1. Where the minister or director exercises any control over a home under this part, all previously existing rights of staff of the home under employment standards legislation or a collective agreement remain in place.”

This particular section refers to when a municipal or joint home is taken over by the director, either under section 134 with the agreement of the municipalities who are involved or under section 135 where the director believes that the home is not being used or likely to be operated with competence, honesty and integrity. I want to ensure that under those circumstance where the director takes control, it’s not the staff in the homes who, particularly in section 135, end up dealing with a situation where there may have been a question of the competence, honesty, integrity etc. of those who were running the operation.

**The Chair:** Any discussion?

**Ms. Smith:** Under this section, if an interim manager is required, they are sometimes required to make changes within the home in order to address the concerns. Again, interim managers are only introduced where there is a

significant risk to residents. We believe that the interim manager should have the flexibility to address whatever concerns arise in the home during that very limited period of time when they are in the home.

**Ms. Martel:** Where in the legislation is the provision that sets out the limit of time that a director might be in the home?

**Ms. Smith:** There’s a maximum period under subsection 137(3). Obviously, it’s the government’s intention to not be managing the homes directly, but to have the homes operated by the licensee. It’s only in limited circumstances where there is a risk to the resident that an interim manager would be put into the home.

**Ms. Martel:** I understand perfectly the need to put someone else into the home if there is a risk to the residents, particularly if there are serious concerns about how the home is being run. What I don’t understand is why that leads to a situation where front-line workers may end up losing some of their rights under a collective agreement or some of their rights under employment standards legislation as a result.

**Ms. Smith:** Can I have a moment, Chair?

**The Chair:** Yes.

**Ms. Smith:** I would just turn Ms. Martel’s attention to section 155, where we say the protection of the workers’ employment standards rights during an interim manager’s occupation of a home—

**Ms. Martel:** Except if I look on that section, under subsection (7), it says:

“Limit on changes to terms and conditions

“(7) Changes to terms and conditions of employment or provisions of a collective agreement agreed to by the interim manager apply only with respect to the period” when the interim manager occupies the home.

So when the interim manager is in the home, changes can occur under that section as well, if I am reading this correctly. Now I’ve got two sections where changes could be made to collective agreements if an interim manager is in the home. To be fair, we also had a provision to delete that section.

**Ms. Smith:** Right, and again, as we discussed, an interim manager would only be going in in a situation where there is risk to the resident. We have to give the interim manager the ability to address that risk however that may need to be addressed. I understand that you have concerns about the collective agreement. However, we feel that there is a need in these very limited circumstances to be able to address those concerns in whatever way the interim manager feels is necessary.

We have put in the provisions with respect to termination pay and severance pay and ensuring that the workers who are affected have all of their rights protected. I do understand that you will have a problem with this section. However, we feel that it is required in order to ensure the safety of our residents in our homes.

**Ms. Martel:** I think that’s the point. I really am quite worried about tying the safety of residents to people’s collective agreements or any suggestion that you need this to let go of people because they’re the ones who are



putting residents at risk. That's how I take this. There are a lot of good people doing a lot of good work in a lot of our homes. The tone of all of that just says to me that what the interim manager may well be looking for is to get rid of a number of employees; I don't know on what grounds and on what basis, but that's where this takes me. I have really serious concerns about moving in that direction, so I want to put that on the record.

**Ms. Smith:** We appreciate those concerns, but as I've said, we have in no way indicated that the tools that the interim manager needs in order to address the issues are specifically related to employees. We're just saying that we want to give them the flexibility to address whatever concerns arise, however they may arise. We do also note that the subsequent employer provisions are also in place for whatever happens after the interim manager, so it's just during a very specific, limited period of time that we would take these steps.

**The Chair:** I will call the vote. Those in favour of the motion? Those opposed? The motion is lost.

Moving to section 138, government motion 280.

**Mr. Lou Rinaldi (Northumberland):** I move that subsection 138(2) of the bill be amended by adding the following clause:

"(c.1) specifying times by which payments required under sections 124 and 125 must be made."

**The Chair:** Any discussion?

**Ms. Smith:** This is with respect to municipal homes that have levies. We understand that under previous legislation there were some timing requirements around that, and we want to give ourselves the ability to insert those through regulations if they're needed.

**The Chair:** I will call the vote. Those in favour? Opposed? It is carried.

I will now ask, shall section 138, as amended, carry? It is carried, moving us to section 139 with PC motion 281.

**Mrs. Witmer:** I move that section 139 of the bill be amended by adding the following subsections:

"Ineligibility

"(4) The minister shall not appoint a person an inspector if the person is ineligible for appointment as an inspector as set out in the regulations.

"Regulations to govern

"(5) The regulations shall govern the qualifications, orientation, and training of inspectors appointed under this act.

"Duty

"(6) Inspectors appointed under this act have a duty to comply with the document known as the 'Code of Professionalism for Compliance Inspection and Enforcement Staff' when acting in the performance of their duties, or with other requirements that may be set out in the regulations."

This deals with the appointment of inspectors. Currently, it says only that the minister may appoint inspectors for the purposes of this act, but I think if you take a look at the tremendous power that's given to inspectors, it's absolutely necessary that we identify what the qualifications would be, as well as to set out their

duty to comply with the code of professionalism for compliance, inspection and enforcement staff. That's the reason for this amendment.

**The Chair:** Discussion? Ms. Smith.

**Ms. Smith:** I would just note that in most other pieces of legislation there are no requirements under regulation for training for inspectors. Under the inspections, investigations and enforcement, training is a matter of individual ministry policy. Under the consumer protection, there is no specificity on training in the legislation, regs or policy, for their inspectors or investigators. Under OMAFRA, food safety and quality, all meat inspectors have a training course that's put out by OMAFRA, but there's nothing in the meat regulations to require it. Under our Nutrient Management Act, the Lieutenant Governor may make regulations, but there are none as of yet. With respect to milk inspection, the only requirement we could find was that under 87(1) of a regulation of the Milk Act, "Subject to subsection (2), no person other than the holder of a cream tester's certificate shall test for milk-fat content or supervise the testing of cream received at a plant." With respect to the Animals for Research Act, there's no requirement. Under the Ministry of the Environment, the Environmental Protection Act, the Ontario Water Resources Act, the Pesticides Act, the Safe Drinking Water Act, we do not have any requirements for training of officers within the acts or regulations. They do, as a matter of policy, set out some requirements. So I would suggest that this should be dealt with in policy and not in regulations, as is consistent with other legislation of the government.

1140

**The Chair:** Thank you. I thought only MPPs had no qualifications. Okay. I will call the vote. Those in favour? Those opposed? The motion is lost.

I will ask, shall section 139 carry? Carried.

Shall section 140 carry? Carried.

Moving to section 141, we have PC motion 282.

**Mrs. Witmer:** I move that subsection 141(1) of the bill be struck out and the following substituted:

"Annual inspections

"(1) Subject to subsections (1.1) and (2), the director may direct that every long-term care home be inspected at least once annually.

"Waiving inspection

"(1.1) Notwithstanding the authority to conduct annual inspections, the director may waive the requirement for an annual inspection, based on verifiable achievements of the long-term care home in producing and sustaining positive outcomes for residents."

This particular amendment is here on behalf of OANHSS, which has talked about the principles and the commitment to care and the need to balance the compliance, the inspection and the enforcement system with an incentive system. In fact, I think that's one of the things we heard about in the legislation: the need to focus on continuous quality improvement, best practices, incentives. They believe that they'd like to see incentive provisions incorporated into the bill to support excellence

within the homes, encourage excellence, and as a result this could be done by having less frequent inspections if indeed homes were excelling.

**The Chair:** Discussion?

**Ms. Smith:** We did hear from a number of people as well who were delighted that we were finally doing surprise annual inspections and wanted to see that included. You'll see in the following motion, 283, that the NDP are looking to ensure that we have annual inspections. Having heard the submissions of the various stakeholders and individuals, we agree that annual inspections continue to be required, and we have actually put in the legislation, through a different motion, recognition provisions for homes that are providing excellent care. So we feel that that will achieve some of the goals that have been set out by some of the stakeholders, and certainly our goal of acknowledging homes that are excelling, and we do feel that an annual inspection is in fact required.

**The Chair:** I will call the vote, then. Those in favour of the motion? Those opposed? The motion is lost.

We have NDP motion 283.

**Ms. Martel:** I move that section 141 of the bill be struck out and the following substituted:

"Annual inspection

"141. Every long-term care home shall be inspected at least once a year."

The provision in the legislation as it now stands allows for subsection (2), which provides for exemptions and says right now that, "The regulations may provide for less frequent inspections for certain classes of long-term care homes, including homes that are recognized as having a good record of compliance." I'm happy if the government would find some other ways to recognize homes, but I don't think that should be in terms of around licensing. I think we should inspect every long-term-care home every year: That's it. If you want to acknowledge good compliance in a home that has best practices, find some other way to do that.

**Ms. Smith:** I said we agree.

**Ms. Martel:** Well, where's your amendment? You've got to drop that, then.

*Interjection.*

**The Chair:** This is additional—

**Ms. Martel:** No, just a clarification with the parliamentary assistant. Right now subsection 141(2) is still in existence, so unless your amendment somewhere else says that you're deleting subsection 141(2)—maybe it does and I just haven't seen it yet; sorry about that.

**Ms. Smith:** No, you're moving that section 141, the whole section, be struck out, and you're only putting in "Every long-term care home shall be inspected at least once a year."

**Ms. Martel:** Yes.

**Ms. Smith:** And we agree with that.

**Ms. Martel:** No, you talked about another amendment, so I wasn't sure—

**Ms. Smith:** No, I was talking about yours.

**Ms. Martel:** No, but you mentioned another amendment that was talking about recognizing—

**Ms. Smith:** Oh, recognizing—we did that yesterday.

**Ms. Martel:** Sorry about the confusion, Chair.

**The Chair:** I will call the vote. There has been a request for a recorded vote.

**Ayes**

Jeffrey, Leal, Martel, Ramal, Rinaldi, Smith.

**The Chair:** The motion is carried.

Shall section 141, as amended, carry? It is carried.

Moving to section 142, shall section 142 carry? Carried.

Now we have section 142.1 as a new section, with government motion 284.

**Ms. Smith:** I move that the bill be amended by adding the following section:

"Meeting with councils

"142.1 Where an inspection is required under section 141, the inspector may meet with the residents' council or the family council, if requested or permitted to do so by the council."

We did refer to this earlier in our discussions about the residents' councils, family councils having some dialogue with the inspector, so this is the amendment that we had referred to earlier.

**The Chair:** Any discussion? I will call the vote. Those in favour? Opposed? It is carried.

Moving to section 143, we have PC motion number 285.

**Mrs. Witmer:** I move that subsection 143(1) of the bill be struck out and the following substituted:

"Powers of entry

"(1) An inspector may at any reasonable time enter a long-term care home, or a joint building providing services to it, in order to conduct an inspection limited to the services provided in the government funded long-term care home."

What has been omitted here is—we still say "services provided," but in the original motion it talks about "in connection with." We want to ensure that this doesn't mean being able to enter into the homes that may be connected to the home or to a doctor or a physiotherapist's office, or even to a head office which may be there, so it restricts it to the services as opposed to the connected buildings.

**The Chair:** Further debate?

**Ms. Smith:** We believe that our section, as drafted, allows us the ability to review the home and those places operating in connection with the home and providing services to it, which allows us to inspect kitchens that are in a retirement home as opposed to a long-term-care home but that are shared by the long-term-care home. It allows us to demand the production of documents that are not being stored in the long-term-care home or in a joint building. I believe that the amendment as presented by Ms. Witmer is too limited. It does not address separate buildings. It does not address a situation where records or



other things are stored in different facilities or office space, and so we will not be supporting her amendment.

**Ms. Martel:** I think I'll make some comments now, because the next amendment that comes says that subsection (2) under "Dwellings" should be deleted entirely. I hear what the parliamentary assistant is saying, but if I read what is placed there, it doesn't reference those particular dwellings and it doesn't give a reference for dwellings at all. So right now, the legislation as currently drafted says, "(2) No inspector shall enter a place that is not in a long-term care home and that is being used as a dwelling, except with the consent of the occupier of the place or under the authority of a warrant."

1150

I move to delete that because, from my perspective, I had no clue what that meant and who the government was going to give authority or where an inspector was going to be able to go into. So as that is currently drafted, it's not limited to what you just talked about, and "dwelling" itself—I stand to be corrected—I don't think has been defined anywhere in the legislation either. So as I read that, that's pretty broad. I don't know who the "occupier of the place" is. I just think you need to have a step back from this and figure out if you can reword this so it's much clearer who you are talking about and where you are talking about, because as I read it, it's pretty open-ended.

**Ms. Smith:** I think I can actually give you the example of what you're looking for. We heard from Vala Monestime Belter from Algonquin Nursing Home in Mattawa. Vala is the director of the long-term-care home. It's a family-run home. I wouldn't be surprised—I don't know for sure, but I wouldn't be surprised—if Vala had a home office where she kept documents that were directly pertinent to the running of the long-term-care home. This would allow the inspector, with the consent of the occupier or with a warrant, to get access to those documents that are directly related to the management of the home.

Again, I would note that in the first section we are requiring that the inspector enter the home or a place operated in connection with the home during a reasonable time in order to conduct the inspection. In the second section, subsection (2), it is very limited by putting it in the negative: "(2) No inspector shall enter a place that is not in a long-term care home and that is being used as a dwelling, except with the consent..." So it's a fairly limited circumstance, and it's only with consent or on the authority of a warrant that we would be going anywhere that would not normally be used in connection with a home or as a long-term-care home.

**Ms. Martel:** I understand what you're trying to do, but as I read this, I don't see it restricted in that way. "No inspector shall enter a place that is not in a long-term care home and that is being used as a dwelling..." Well, whose dwelling, and where? It doesn't even say "dwelling of the operator who lives next door and who might hold records off-site that we need to see." You've got some vague reference to "dwelling" that's not defined anywhere else in the bill and doesn't even say "attached

to a long-term care home" or "that is the home of the operator."

**Ms. Smith:** But I think you're losing the sense that you can't do that unless you have consent or you have a warrant. So it's only in very limited circumstances that an inspector could go into a dwelling: if they have consent or if they have a warrant. So what we're saying is that an inspector can't go into just any place. They have to have a warrant, and in order to get a warrant, they would have to justify why they wanted whatever documents or entry into whatever premises.

**Ms. Martel:** Why wouldn't you make it clear you're talking about someone who is linked to the long-term-care home in some way?

**Ms. Smith:** It's very difficult to limit it in that circumstance. Going back to my Vala circumstance, if Vala has her home office in her brother's house because her house is too small or whatever—I mean, how would you have us limit it? We are limiting it by saying that you can't go into a dwelling unless you have permission or you have a warrant, which is a pretty high threshold for gaining entry into a dwelling.

**Ms. Martel:** Okay.

**Mrs. Witmer:** Is there currently something within any of the acts that we're amalgamating here that speaks to this issue of powers of entry and that might be similar to this? What's currently—

**Ms. Smith:** You must have great recall, Mrs. Witmer. It is in the Nursing Homes Act, the same language.

**Mrs. Witmer:** The same language.

**Ms. Smith:** As well, this language, I'm advised by ministry counsel, is used in most inspection provisions in other legislation. This is the kind of language that they use.

**Mrs. Witmer:** So you're saying that both 143(1) and 143(2) are already written somewhere in—

**Ms. Smith:** Sorry. In the Nursing Homes Act. I would direct you to subsection 24(3): "No inspector shall enter a place that is not in a nursing home and that is being used as a dwelling, except with the consent of the occupier of the place or under the authority of a warrant issued under section 158 of the Provincial Offences Act." So it's right there.

**Ms. Martel:** If the Nursing Homes Act is out—because the next section is linked to this—does the next section also talk about "the operations on the premises"? I'm assuming that the language is following; maybe I shouldn't make that assumption. Sorry about that.

**Ms. Smith:** Sorry. What was your question?

**Ms. Martel:** If you take a look at the current act right now, under 144(1) it says an inspector conducting an inspection may inspect, clearly, "(i) the premises of the long-term care home or the premises of a place operated in connection with the home and providing services to it," and, "(ii) the operations on the premises."

I had an amendment that followed that also expressed concern about that "(ii) the operations on the premises": What was that and what did that mean?

**Ms. Smith:** Okay. In the Nursing Homes Act, it's actually much longer. We've kind of abridged it. But let me just tell you that the inspector,

"(a) may at all reasonable times enter and inspect a nursing home; and

"(b) may, if he or she has reasonable grounds to believe that records or other things pertaining to a nursing home are kept in a place that is not in the home, enter the place at all reasonable times in order to inspect such records and other things."

Then, "(3) No inspector shall enter a place that is not in a nursing home and that is being used as a dwelling, except with the consent of the occupier of the place"—so that's the section we talked about.

"(4) An inspector conducting an inspection under this section,

"(a) may inspect the premises of the nursing home and the operations on the premises;

"(b) may inspect a record or other things relevant....

"(c) may demand the production....

"(e) may conduct such examinations or tests as are reasonably necessary for the inspection...."

It goes on at some length, but those are the places they talk about.

**Ms. Martel:** Premises? Okay.

**Ms. Smith:** If you want, I can give you this during the lunch break and you can have a look.

**Ms. Martel:** Thanks, Chair.

**The Chair:** I will call the vote. Those in favour of the motion? Those opposed? The motion is lost.

That brings us to NDP motion 286.

**Ms. Martel:** In light of the discussion that we've just had, I will withdraw this amendment.

**The Chair:** Okay. I will now ask the question: Shall section 143 carry? It is carried.

It is close enough to 12 o'clock. With the committee's indulgence, this committee is recessed until 1 o'clock.

*The committee recessed from 1157 to 1308.*

**The Chair:** The committee is back in session. We are dealing next with PC motion 287.

**Mrs. Witmer:** Based on our previous discussion on this issue, I'm going to be withdrawing it.

**The Chair:** We move next, then, to NDP motion 288.

**Ms. Martel:** Based on the discussion we had earlier, I'm going to withdraw that motion as well.

**The Chair:** That brings us, then, to NDP motion 289.

**Ms. Martel:** This was a reference to operations on other premises, and given our discussion, I'll withdraw that.

**The Chair:** NDP motion 290. Ms. Martel.

**Ms. Martel:** This one I'm not going to withdraw.

I move that clause 144(1)(d) of the bill be amended by striking out "counsel" and substituting "a union representative or counsel."

This is in the section on inspection and what an inspector may do. There are a number of things he can do, and one is to "question a person, subject to the person's right to have counsel present during the questioning." The addition is, particularly in a long-term-care home,

the right of that person to have their union representative, not just counsel, who may be a lawyer, which they may not be able to afford. It's providing for both opportunities.

**Ms. Smith:** We would argue that the inclusion of the word "counsel" does not preclude union counsel from representing, so we don't see the need to amend to include a union representative.

**Ms. Martel:** If I might, Mr. Chair, most unions don't have counsels in every home. Many unions, though, have a union representative in every home. In terms of the actual practical ability of an inspector to come in and a union being allowed to have a representative, in nine cases out of 10 they will not be able to have legal counsel there from the union because there is a limited number of people involved. They would be much more likely to have a union representative. So I think from a practical perspective it makes sense to allow them to at least have a union representative, because the likelihood of their having union counsel is not very likely.

**The Chair:** Any additional debate?

**Ms. Smith:** Yes. There's a feeling from Ms. Martel that she would like union representatives to be addressed by the inspector or to have a conversation with the inspector. There's no provision in this bill to preclude that from happening and obviously the inspector, through clause (d), may question a person, and that would be any person, subject to the person's right to have counsel. I think if we start putting requirements around the person's right to have a union representative and on and on, then we are in fact making this a more onerous process than if just the inspector is allowed to speak to anyone, as is allowed by clause (d).

**Ms. Martel:** I'm not trying to make it more onerous; I'm trying to make it more practical. In truth, if a staff person who was part of a union wanted to have counsel present because the inspector wanted to question them for whatever reason, their being able to exercise their ability to have counsel is unlikely. That's the only point I'm trying to make. I don't question that the inspector can talk to them and I don't question that they'll probably want to do that. The issue is, are we really putting in place a provision that would support a person's right to have counsel? I'm saying, in most cases, no. So the better way to get around that is to say "union representative," because that's far more likely to be what you're going to run into in a home.

**The Chair:** I'll call the vote. I'd ask for those in favour of the motion. Those opposed? The motion is lost.

We move next to NDP motion 291.

**Ms. Martel:** I move that subsection 144(1) of the bill be amended by adding the following clause:

"(d.1) may consult with non-management staff and their unions."

Right now there is no provision in the bill at all to consult with unions. I would like to make that a provision. Even though we've had a discussion about this, I would really encourage the government to consider supporting this. There are a number of things that can be done. I



think the ability of consulting with non-management staff and their unions, especially with respect to an inspection—what they feel about the home, what they see, what they think needs to be done—given that they are the front-line workers in that home, is an important provision to give them. We have said that residents' councils and family councils may, if they want to, talk to an inspector, and I'm trying to find a way to allow that same type of conversation to occur with a lot of the people who are actually providing the front-line services.

**Ms. Smith:** We would argue that "(d) may question a person" is broad enough to include anyone, and obviously would include front-line workers whether they're represented or not. We don't think that it would be appropriate to start delineating in any particular order which individuals in a home should be spoken to.

**Ms. Martel:** Chair, if I might.

You specifically, in other parts of the bill, reference family councils and residents' councils and their ability to approach and talk to an inspector. In this case, the same opportunity is not afforded to a union. It's up to the inspector to decide whether or not he may question a person, whoever that may be. In the other proposals that we put forward, I think the onus is the reverse, that the family council and the residents' council can ask for that and it will be done. There's not the same opportunity afforded to front-line staff and I think there should be.

**Ms. Smith:** And I would just point out that the inspector may meet with the family council or the residents' council. The language is "may." In fact, they would not fall under the definition of "person" under the legislation because they are specific entities. The "person" in clause (d) is broad enough to include any worker in the home.

**Ms. Martel:** I'm trying to flip through the amendments, because I'm sure it says "may," but I think it also says "upon the request." I can't find the amendments quickly, but if I remember the ones we passed this morning, the provision was stronger in that, to say that if the family and the residents' council wanted to do that, then they would be afforded that opportunity. It's not the same thing here. That's not what is happening at all.

**The Chair:** Further discussion? I'll call the vote. Those in favour of the motion? Those opposed? The motion is lost.

Still on 144, PC motion 292.

**Mrs. Witmer:** I move that the definition of "record" in subsection 144(8) of the bill be struck out and the following substituted:

"record" means any document or record of information, in any form, including a record of personal health information within the meaning of the Personal Health Information Protection Act, 2004, but does not include information that is collected by or prepared for a quality of care committee within the meaning of the Quality of Care Information Protection Act, 2004,

"(a) for the sole or primary purpose of assisting the quality of care committee in carrying out its functions, or

"(b) that relates solely or primarily to any activity that the quality of care committee carries on as part of its functions."

This deals with the definition of "record." It's believed, and this amendment speaks to it, that the definition of "record" should incorporate the exclusions that are currently set out in the Quality of Care Information Protection Act. I understand that the long-term-care providers were successful in securing inclusion as prescribed entities under the QCIPA in an attempt to create a health-system-wide approach to the collection, use and disclosure of quality-of-care information by the quality-of-care committee of the home as established under QCIPA. That's the reason for the amendment.

**The Chair:** Any additional discussion on this motion?

**Ms. Smith:** Yes. I believe this amendment is unnecessary. The proposed act does not override QCIPA, so there's no need to exclude QCIPA from the definition of "record." As well, the exclusion that's included in the latter part of this amendment is not complete. So there are documents that are not included in this. Because QCIPA already applies, I don't think it's necessary to include this.

**Mrs. Witmer:** If that is indeed the case, I'd be prepared to withdraw it.

**The Chair:** Amendment 292 is withdrawn. That concludes section 144.

Shall section 144 carry? Carried.

Shall section 145 carry? Carried.

We now move to section 146, NDP motion 293.

**Ms. Martel:** I move that subsection 146(2) of the bill be amended by adding "and to representatives of the non-management staff and their unions" at the end.

Section 146 references the inspection report and who is entitled to receive a copy of it. The current provision says that an inspector will prepare a report and give a copy of it to the licensee, to the residents' council and to the family council, if any—if the family council exists in that home. I'm suggesting that we amend it to ensure that a copy from the inspector is also given to the union and their representatives. These are the front-line workers. If there are changes that need to be made, if there are things that have to be done, they should be able to see that directly in the report without having to be briefed on it by the inspector. Since we're already giving copies to the residents' council and the family council, I think it makes great sense to give a copy to the people who are actually doing the front-line work.

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**Ms. Smith:** These inspection reports are posted in the home as required in the posting provisions. They are also posted on the Web and are publicly available. We have looked at some other pieces of legislation where inspections are done, and it is my information at this point that there is no other requirement under legislation for inspectors' reports to be provided to non-management staff and their unions. So I would say that this is unnecessary given that there are other avenues to obtain copies of the reports.

**Ms. Martel:** If it's unnecessary, I'm wondering why you have a provision here that says that the inspector is going to give it to the residents' council and the family council. I guess they could go look at the wall too and see where it's posted, but that's not what you're doing and I agree with that. You're talking about the people who are delivering the front-line care in the homes who may be the subject of the inspection, in terms of people making allegations or raising concerns about the appropriateness of care. If you are going to give it to two groups already in the home, I don't see what the problem is with giving it to the folks who are actually doing the work. I'm sorry.

**Ms. Smith:** I think we'll continue to agree to disagree on this one. The homes are there for the residents. That's why we have them, and it's important that they get that information. The unions and workers can obtain the information as it's posted.

**The Chair:** I will call the vote. Those in favour? Those opposed? The motion is lost.

Subsection 146(3), PC motion 294.

**Mrs. Witmer:** I move that subsection 146(3) of the bill be amended by striking out "shall" and substituting "may."

The current wording is that if the inspector finds that the licensee has not complied with the requirement under this act, the inspector "shall"—I'm changing that to "may"—document the non-compliance. The approach as it is worded currently would require documentation of each and every area of non-compliance, no matter how small and despite the potential immediate rectification by homes. This approach, I am told, could translate into staff time being spent on some relatively trivial matters—we have heard about some of those examples—with less time left to deal with the truly significant, hands-on personal care issues where staff should be focusing their attention. I think we need to take a look at setting out appropriate measures to manage and make improvements where performance does not meet the provincial standards and not simply ticket every non-compliance. This wording would compel inspectors to document all areas of non-compliance. The suggestion here is that we need to take a look at moving away from what some people in their presentations referred to as a shame-and-blame approach, but recognize that through interactions amongst staff, care systems, operational policies and procedures we do address the root problems and solutions are developed.

**Ms. Smith:** Over the last three years I've heard a lot about inconsistency in the compliance and enforcement. What we're doing through this legislation is ensuring that we have consistency across the province. We can only achieve that consistency if we have consistent reporting of non-compliance. Allowing for discretion of the inspectors does not allow for consistency. We think that it's important to achieve that kind of consistency and to allow for all of the homes to understand what the expectations are that are to be met.

I would just note that in Mrs. Witmer's discussion she noted that this would lead to documentation about every

little thing. But this is documentation by the inspector. This is not the spilled-juice example that some of the stakeholder groups kept using, which is really just a red herring. This is about an inspector coming into a home and finding non-compliance and their documentation, not staff documentation. We think it's very important to have consistency in our compliance in all of our homes to ensure that they are all meeting the standards. I would note and refer for the committee that a US review on nursing home quality in 2003 noted under-reporting in a substantial number of homes for immediate sanctions, and that was because documentation was not being kept by their inspectors on a consistent basis. So we feel that this is absolutely imperative to ensure the consistency and integrity of the compliance and enforcement system.

**The Chair:** I will call the vote. Those in favour? Opposed? The motion is lost.

That brings us to NDP motion 295.

**Ms. Martel:** There have been amendments that have already made the posting of an inspection report in the home a mandated responsibility, so I'll withdraw this amendment.

**Ms. Smith:** I would just note as well that under subsection 77(1), we do note that it has to be posted in a conspicuous place. That was part of yours; it was already addressed.

**The Chair:** Okay. I will ask the question: Shall section 146 carry? It is carried.

Shall sections 147 and 148 carry? Carried.

Section 149 is started with NDP motion 296.

**Ms. Martel:** I move that section 149 of the bill be amended by adding the following subsections:

"Copies to certain groups

"(2) The inspector shall provide a copy of everything done under subsection (1) to the residents' council of the home, the family council and to the non-management staff of the home and their unions.

"Appeal

"(3) Anybody mentioned in subsection (2) may appeal to the director if the inspector has taken any action other than issuing an order or referring the matter to the director."

This follows from an earlier discussion we had about who should get the inspection reports under this particular section. It's an issue of enforcement of orders and what is being done. I continue to believe that if we're going to get at that information, that information should be given to the relevant parties in the home, including workers and their unions, resident councils, and family councils as well.

**The Chair:** Debate?

**Ms. Smith:** Yes. We do have a requirement that the inspector provide the annual inspection report both to the family councils and the residents' councils, as Ms. Martel has noted, as well as that it be posted. What Ms. Martel is talking about now is providing to these groups any written notification and written requests to prepare a plan of correction or an order in the compliance provisions. We didn't hear from residents' or family councils that



they wanted to receive this. We did hear that they wanted to receive the annual inspection report and they are, so I don't know where this request is coming from. I think it's inappropriate. Most of these things are included in the final inspection report that's written, but to go into the detail of every single issuing of a written notification or written request to prepare a written plan or an order would be far too detailed and require far too much work on behalf of the inspector, who in this case is compiling a final inspection report as well.

**Ms. Martel:** I'm sorry to hear that you think it's inappropriate. It was given to us by the Ontario Nurses' Association. I'm sure they'll feel badly that you think it was an inappropriate request to make. I don't think it's inappropriate at all. You're talking about the action that an inspector is going to take if there's non-compliance. We're upping the ante because now we've got a situation where the licensee is not complying with the requirement under the act or with an order. So I think it's even more incumbent, when that is the situation—where the licensee is not even complying—that the people who make the home their home, who are represented by family councils, residents' councils and people who work there, be allowed to know what that is, how serious it is and question the licensee as to why it is they don't think they have to comply. I think the only way you're going to get that is if it's given to some other people other than just a transaction, so to speak, between the inspector and the licensee.

**Ms. Smith:** They are given a copy of the final report, which includes any findings of non-compliance for the family council and residents' council. I think it's a bit presumptuous of the Ontario Nurses' Association to presume that the family councils and residents' councils wanted the details of all of these written orders and notifications as well as wanting a level of appeal that they never requested. We never heard from any of those groups wanting that.

**Ms. Martel:** Even if we weren't speaking for them—and if you think they shouldn't have been speaking for them—they certainly have a right to speak for themselves, which is why they said they would think that this should be available to the non-management staff of the homes and their unions, and I think so too.

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**The Chair:** I'll call the vote. Those in favour of the motion? Those opposed? The motion is lost.

PC motion 297.

**Mrs. Witmer:** I move that section 149 of the bill be struck out and the following substituted:

"Actions by inspector if non-compliance found

"149 If an inspector finds that a licensee has not complied with a requirement under this act, the inspector shall issue a written notification to the licensee requiring,

"(a) voluntary compliance; or

"(b) a written plan of correction for achieving compliance to be implemented voluntarily."

I should say up front that in order for this amendment to be accepted, we'd really have to get acceptance for

149, 150, 151, 152 and 153, because the attempt that is being made here is to set out staged consequences to non-compliance that will recognize what I think you would have to acknowledge has been the willingness, historically, of the majority of long-term-care homes to comply with the ministry requirements and the ability of the ministry to compel recalcitrant licensees to comply through increasing sanctions. The revocation of the licence remains the final sanction.

What we have here is a recommendation by the Ontario Long Term Care Association that is proposing the reordering of these sections to reflect the staging that would result in the following graduated process: voluntary compliance; failure to comply results in an order to undertake or refrain from activity if there is an immediate risk of harm to residents or a second opportunity to voluntarily comply; failure to comply with the step above then results in closure of the home to admissions; if compliance has still not yet occurred, the director can make a mandatory management order; and the last resort is revocation.

This is a belief that this type of approach would be more successful in meeting the above goals than a process based on open-ended orders forcing homes to do anything based on the opinion of the person making the order.

That's the rationale for this.

**Ms. Smith:** I'm happy to speak to 149 through 153 or motions 297 to 301 at the same time. The proposals that have been put forward by the OLTC and Ms. Witmer are in fact watering down what exists presently. We've heard in certain situations that people are concerned about enforcement and compliance and the ability to move quickly to address problems in homes. The regime that we have set out in the legislation, as is presently drafted, allows the ministry more tools to deal expeditiously with problems as they arise, to deal with problems as they arise both quickly and accurately.

The regime that Ms. Witmer is setting out would require us to go through step 1, step 2, step 3, step 4, despite the fact that the compliance issue may be of a serious nature and require us to move directly to step 4. It would also require us to go back to step 1. If we felt that at step 3 we hadn't succeeded, we'd have to start over again. That is just creating chaos in a compliance system.

We've created both a pyramid and a grid in order to ensure that we are able to achieve the compliance that we need in all of our homes. We are able to move forward with different types of tools and different types of mechanisms to ensure compliance and to ensure that our homes are able to comply.

Ms. Witmer is as well, in some cases, setting a high threshold by setting out in her clause 150(2)(b) that the inspector has to reasonably believe that there is an immediate risk of harm to residents before some actions are taken. We believe that in our regime we've set out the appropriate risks that are necessary before certain actions are taken. We are trying to give our compliance advisers and our inspectors the tools that they need in order to address problems as they arise.

I would also note that in her motion 300 she is introducing the notion of cease admissions. We have actually put that in the admissions section where we think it's more appropriately dealt with, not as a compliance issue but as a risk to our residents and potential residents.

With respect to all of the motions that she has put forward, I would suggest that they don't do the job. We've had some concerns about the ability to manage in the past. We want to give ourselves the tools to better address concerns in the future and we feel that our legislation does just that.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is lost.

Shall section 149 carry? It is carried.

Section 150: PC motion 298.

**Mrs. Witmer:** As I say, they all have to go together. So I would withdraw section 150, but I think we need to recognize that this section would have allowed for immediate compliance if there's reasonable risk.

**The Chair:** That brings us, then, to NDP motion 299.

**Ms. Martel:** There is a difference in the issues around when the order will be made, so I'm not going to withdraw this. I'll read it into the record.

"Compliance

"150(1) An inspector or the director may order a licensee to do anything, or to refrain from doing anything, to achieve compliance with a requirement under this act, provided it does not jeopardize compliance with another act or regulation.

"When may be made

"(2) An order may only be made under this section if,

"(a) the director issued a written notification to the licensee under paragraph 1 of section 149;

"(b) a plan of correction under paragraph 2 of section 149 failed to achieve compliance within a reasonable time; or

"(c) there is an immediate risk of harm to a resident of the home.

"Restrictions

"(3) No inspector or the director shall make an order that,

"(a) is not provided for in funding provided by the ministry under section 88;

"(b) requires structural repairs or alterations to a building, structure or premise that was constructed in accordance with the ministry 1992 or 1998 design standards for long-term care homes; or

"(c) overturns the care ordered by a health care professional as defined in the Regulated Health Professions Act, 1991."

The section that is different than what Mrs. Witmer put in follows through when an order will be made, which makes it clear that that can happen when there is immediate risk of harm to the resident of the home so that the director can move right to that. We're also making it clear that the director has the opportunity or the obligation to do that and then setting out in that section when that can happen. So it is very clear that if there is

immediate risk of harm to the resident, then the order will be made.

**Ms. Smith:** All of the stuff I said before, and, with respect to your restrictions under subsection (3), you are advising that no inspector or director shall make an order that "requires structural repairs or alterations to a building" in conjunction with, I believe you meant, the 1972 standards, not 1992. But given that, what you're saying is that if there is water dripping on the bed of a resident, an inspector cannot make an order that that be repaired because that would require a structural repair or alteration and they're not allowed to issue those orders under this provision, as it's written.

**Ms. Martel:** Except, (c) says "there is an immediate risk of harm to a resident of the home," and there would be in that case.

**Ms. Smith:** There are other structural issues that may not be "immediate risk of harm" but that need to be addressed.

The other question I have for you is, in 150(1) you say, "provided it does not jeopardize compliance with another act or regulation." I'm unclear as to what that would mean.

**Ms. Martel:** Long-term-care homes operate under other provisions from other acts as well. The idea was that, provided it wouldn't put them into jeopardy because they have obligations under another act, then the director or the inspector could do just that. It was to try to avoid, where there may be two competing sets of legislation, that failure to comply under another act was going to jeopardize the home or the licensee.

**Ms. Smith:** Call the question.

1340

**The Chair:** I'll call the question. Those in favour of the motion? Opposed? The motion is lost.

Shall section 150 carry? Carried.

Section 151. That brings us to PC motion 300.

**Mrs. Witmer:** Again, this is part of a package; I would withdraw that.

**The Chair:** It is withdrawn.

Shall section 151 carry? Carried.

That moves us to section 152 and PC motion 301.

**Mrs. Witmer:** Again, I would withdraw that because they were all interconnected.

**The Chair:** Thank you.

Shall section 152 carry? Carried.

Shall section 153 carry? Carried.

Moving to section 154, we have government motion 302.

**Ms. Smith:** I move that the portion of clause 154(2)(c) before subclause (i) and clause 154(2)(e) of the bill be struck out and the following substituted:

"(c) the conduct of the licensee, a person with a controlling interest in the licensee or, where the licensee is a corporation, the conduct of the officers or directors, affords reasonable grounds to believe,

"(e) a person has gained a controlling interest in the licensee without the approval of the director, contrary to



section 107, or a condition of such an approval has been breached.”

This is part of our ongoing amendments to provide some clarity around controlling interest.

**The Chair:** Any discussion or debate? I'll call the vote. Those in favour? Those opposed? It is carried.

Government motion 303.

**Ms. Smith:** I move that subsection 154(4) of the bill be amended by striking out “who wish to be relocated.”

This is again in order to provide clarity, because if we have an interim manager in place and we are looking at revoking the licence, we would be relocating everyone.

**The Chair:** I'll call the vote. Those in favour? Opposed? Carried.

I will ask the question: Shall section 154, as amended, carry? It is carried.

We are moving to section 155 and NDP motion 304.

**Ms. Martel:** I move that subsection 155(7) of the bill be struck out.

This follows from an amendment that I moved earlier, 137(1), which talked about protecting workers' rights when a minister or a director exercises control over a home in terms of having an interim manager. I would like this particular section deleted because it continues on in the same vein as other government amendments which say that during the time that an interim manager occupies or operates a home, changes to the terms and conditions of employment under a collective agreement can be changed. That should also, I suspect, mean that changes under the Employment Standards Act could be made. We had a broad discussion on that, but the only other point I'd make is that because this was raised as a concern around residents and their safety, I'm just wondering why the changes apply only to those people who have collective agreements. If the individual in charge, who might be causing the grief and causing the concern to safety, is someone outside of a union and has a contract with a home, I don't see references to changing those terms and conditions, if necessary, in order to fix the problem. So I'm looking at this and I continue to feel that it's one-sided in terms of who we think the problem is and how we think we're going to manage it.

Let me give you another example. If you've got a home that's dealing with a contracted-out food service agency and you've got significant problems with them and what's going on in the home, I don't see provisions to change that contract in order to rectify that situation.

I wish the government, in looking at this, if they're really concerned about safety, and I trust that they are, would be looking at not just what would be required to do something about unionized staff, but other folks in the home who are not unionized or who operate on a contract who may well be the source of the problem as well.

**The Chair:** Ms. Smith?

**Ms. Smith:** Under section 6, “1. The interim manager has all of the powers of the licensee to occupy, manage, operate and administer the home,” which would allow them to enter into or end any contract that they have with any independent operator, any contractor or with non-

unionized employees. So I don't see where Ms. Martel's concerns are around non-unionized when they have the same ability as a licensee would have to manage their staff.

**Ms. Martel:** Can I ask where the reference is to contracts, like outside the home?

**Ms. Smith:** “...occupy, manage, operate and administer the home.”

**Ms. Martel:** No, if they're contracting out services.

**Ms. Smith:** That would be part of the managing or operating the home. They have all the powers of the licensee. If a licensee has a contract with a third party contractor, then the interim manager has all the powers of the licensee, who steps into the place of the licensee to deal with any contract.

**Ms. Martel:** Is this 6(1)?

**Ms. Smith:** Yes, 6(1).

**Ms. Martel:** Okay, in that particular section, they're going to continue to get termination and pay, so there won't be a change to employment standards. Does that provision then continue for staff who are unionized?

**Ms. Smith:** I'm sorry. Can you repeat that?

**Ms. Martel:** If you look at section 6, it says, “[T]he interim manager may pay an employee whose employment is continued under subsection (2) any other termination pay or severance pay and entitlements the employee may be entitled to if the interim manager lays off the employee.” They're going to be entitled to severance pay and termination. Does that carry over into the next section? If you're letting unionized staff go, do they get severance and termination pay as well?

**Ms. Smith:** I would point out first off that I think you've answered your own question as far as employment contracts by pointing to subsection (6), so that's good.

Subsection (7) says, “Changes to terms and conditions of employment or provisions of a collective agreement agreed to by the interim manager....” So they would have to be agreed to by the union if there were changes to a collective agreement.

**Ms. Martel:** No. Doesn't this section say that there will be no changes outside of the period of time when the interim manager occupies; the changes will be during the term that he or she is managing on an interim basis?

**Ms. Smith:** And they're agreed to. The changes are agreed to in the period during which the interim manager occupies or operates, yes.

**Ms. Martel:** Agreed to by the interim manager.

**Ms. Smith:** You have to agree with somebody.

**Ms. Martel:** Yes, but where's the union? “Agreed to by the interim manager.”

**Ms. Smith:** They would be the ones on the other side of a collective agreement, I would think.

**Ms. Martel:** My apologies. I thought this one flowed also from 137(1), because it was referenced by you as well as being the other area where this would apply. My concern has been to make sure that this doesn't all fall on the back of unionized employees. So if I'm wrong about that section, I apologize.

I would withdraw the amendment.

**The Chair:** Okay. The amendment is withdrawn.  
Shall section 155 carry? Carried.  
Section 156, PC motion 305.

**Mrs. Witmer:** I move that section 156 of the bill be amended in the section before clause (a) by striking out “150 to 154” and substituting “153 or 154.”

Since the recommendations for amendments for sections 149 to 154 were not considered by the government, by making this change here at this time—as it’s worded right now, I understand that this section currently removes a fundamental principle of defence, and it is reasonable not to have recourse to a defence of due diligence if the ministry is issuing an order for mandatory management or revocation of a licence. And if the graduated sanctions triangle is not amended, as it was not amended in sections 149 to 154, a due-diligence defence is required as it relates to compliance orders, work and activity orders, and funding being returned. So that’s why I’ve introduced this particular motion.

1350

**The Chair:** Any discussion?

**Ms. Smith:** We think it’s important that our licensees comply with the standards as we set out. Currently, in the service agreements between the ministry and the licensee, we require our licensees to comply with the long-term-care home manual, which contains most of the current standards. The agreement previously said “take reasonable steps” but now says “shall comply.” So what we’re requiring is the same as what presently exists. We do note that there is an appeal provision available if a licensee objects to the actions taken. The requirement is that they comply with our standards. We actually don’t want to enter into a prolonged discussion of what reasonable steps may or may not have been taken; we want to ensure that our standards are met.

**The Chair:** Shall I call the vote? Those in favour of the motion? Opposed? The motion is lost.

Still on 156, NDP motion 306.

**Ms. Martel:** I’d like to speak to this too, so I’m going to just introduce it.

I move that section 156 of the bill be struck out and the following substituted:

“Reasonableness

“156(1) Subject to subsection (2), the authority to make an order under sections 150 to 154 against a licensee who has not complied with a requirement under this act shall not be exercised if there is evidence that,

“(a) the licensee took all reasonable steps to prevent the non-compliance; or

“(b) at the time of the non-compliance, the licensee had an honest and reasonable belief in a state of facts that, if true, would have resulted in there not being any non-compliance.

“Immediate risk, etc

“(2) This section does not prevent an order where there is immediate risk of harm to a resident of the home, or the issuance of a written notification or written request to the licensee under paragraph 1 of section 149.”

The concern I had with the way the current motion is worded in the bill really comes from the top section of 156, where it says, “The authority to make an order under sections 150 to 154 against a licensee who has not complied with a requirement under this act may be exercised whether or not....” I don’t understand why the government is using “whether or not,” especially if it’s clear that the licensee took all reasonable steps and at the time they had an honest and reasonable belief in that fact. I just was concerned about the “whether or not” and why, if they had done everything that they could have or should have, that wouldn’t be acceptable.

**Ms. Smith:** Again, it’s part of a compliance regime where we expect them to meet our standards. Whether or not they’ve taken reasonable steps would lead to a whole discussion around that. What we want to be able to do is to enforce our standards through this compliance regime. They do have the ability to appeal if they feel that they should not receive that type of penalty. But if there is non-compliance we want to be able to address it, and that’s what this regime allows us to do.

**Ms. Martel:** And you don’t feel that it’s addressed in the section that was different from Ms. Witmer’s that talks about immediate risk?

**Ms. Smith:** No.

**Ms. Martel:** Okay.

**The Chair:** Shall I call the vote? Those in favour of the motion? Opposed? The motion is lost.

I will ask, shall section 156 carry? Carried.

I will ask, shall sections 157 to 159 carry? Carried.

That brings us to section 160, with government motion 307.

**Ms. Smith:** I move that subsection 160(2) of the bill be amended by striking out “14” and substituting “28.”

We heard from OANHSS and a number of the other stakeholders that they needed more time in order to address the request for review or an appeal procedure, and because, in the case of municipal homes in particular, the management boards often only meet on a monthly basis, we felt that 28 days was more appropriate. So we’ve heard that request, and we are acquiescing.

**The Chair:** I will call the vote. Those in favour? Opposed? Carried.

Government motion number 308.

**Ms. Smith:** I move that subsection 160(6) of the bill be amended by striking out “amended” at the end and substituting “altered.”

Again, this is just for clarity. It’s my understanding that the director’s decisions are sometimes altered but not amended.

**The Chair:** I’m calling the vote. Those in favour? Opposed? Carried.

Government motion 309.

**Ms. Smith:** I move that subsection 160(7) of the bill be amended by striking out “14” wherever it appears, and substituting in each case “28.”

**The Chair:** Those in favour? Those opposed? It is carried.

Shall section 160, as amended, carry? It is carried.



Moving to section 161, shall section 161 carry? Carried.

Moving to new section 161.1, NDP motion 310.

**Ms. Martel:** I move that the bill be amended by adding the following section:

"Other parties

"161.1 The residents' council of the long-term care home, the family council, and the non-management staff of the home and their unions are parties to any request for review or appeal under section 160 or 161."

I've spoken at some length about participation by unions and their representatives, and my feeling is the same on this issue as well.

**Ms. Smith:** For consistency, my position is the same on this one as well.

**The Chair:** No other discussion or debate? Those in favour of the motion? Those opposed? The motion is lost.

Section 162, government motion 311.

**Ms. Smith:** I move that section 162 of the bill be amended by striking out "15" and substituting "28."

**The Chair:** Any debate? Those in favour? Opposed? It is carried.

Shall section 162, as amended, carry? Carried.

Shall sections 163 to 167, inclusive, carry? They are carried.

That brings us to section 168, PC motion 312.

**Mrs. Witmer:** I move that section 168 of the bill be amended by adding "that applies to an order under section 153 and 154" at the end.

This section, as currently worded, absolves the ministry of any accountability for the publicly funded LTC homes sector. It is reasonable not to have recourse to a defence of sufficiency of funding if the ministry is issuing an order for mandatory management or revocation of a licence.

**Ms. Smith:** I would just repeat what we've said around compliance and enforcement. I think if the sufficiency of funding is not a consideration in these circumstances, it shouldn't be a consideration in imposing lesser penalties. This does not reflect the government's support of the system but in fact would be used by a home in its own determination of where it has put its funding.

**The Chair:** I will call the vote. Those in favour? Opposed? The motion is lost.

Prior to calling for the vote on section 168, I will open the floor to debate.

1400

**Mrs. Witmer:** I also had a motion that we would recommend voting against the entire section. OANHSS had suggested that this section should be deleted. They point out that the entire bill is a very complex piece of legislation. It has very substantial and far-reaching implications, and I think we're seeing a little bit of that today; we certainly did when we were out participating in hearings. It establishes many new requirements, many new standards, and it does place substantial new obligations on the homes without any responsibility or accountability on the part of the government.

At the same time, there really were very serious concerns expressed to us by the people who appeared in front of us that there was no assurance of adequate funding for homes to comply with the many requirements of the bill. There was concern that there would be perhaps non-compliance because of a lack of appropriate resources. This was a concern of OANHSS. It was RPNAO who also recommended the removal of section 168, which prohibits inadequacy of funding as a defence under part IX. There were grave concerns about the lack of funding.

**Ms. Martel:** Right after Mrs. Witmer's motion is ours, which also recommends voting against section 168. That specific section says, "The sufficiency of the funding provided to a licensee from any source shall not be considered in any review or appeal under this part." My sense of it would be that a party, if it is allowed to proceed to an appeal board and if it is also allowed to appeal to the Divisional Court, which it appears to be able to do under other sections within this particular set of provisions, should be allowed to make its case, and the appeal board or the Divisional Court would rule from there. But I think that given that we are giving them the opportunity to appeal not just to one level but to various levels, including the Divisional Court, that case should be heard and the appeal board or the Divisional Court would make the decision as to whether or not there was sufficient funding on that basis, whether or not what has happened was the result of insufficient funding. But it would be up to them to make that determination.

**Ms. Smith:** Just to confirm, under this sanction scheme, the licensee can appeal. The appeals from the inspector go to the director; the appeals from the director go to HSARB. The licensee's right to appeal is not in any way being restricted, and they can appeal on the basis of fact, law, or law and fact.

Just to address the final point, I do believe that it would be inappropriate for HSARB to be placed in a position of determining whether or not funding provided to the licensee was sufficient. I don't think that would be their jurisdiction. We will obviously be supporting section 168.

**The Chair:** I'm going to call the vote. Shall section 168 carry? It is carried.

New section, 168.1: PC motion 315.

**Mrs. Witmer:** I move that the bill be amended by adding the following section:

"Incentives

"168.1 The director has the authority to provide incentives to recognized well-run long-term care homes."

There is very little in this bill to deal with rewarding people or providing incentives to make them provide the best environment within their home to meet the needs of the residents. We heard from OANHSS, we heard from the regional municipality of Waterloo, we heard from the Catholic Health Association of Ontario and we heard from the Alzheimer's Society about the need to provide some incentives. They said that there was a need to support an environment that encouraged innovation,

excellence, with evaluation and monitoring focused on outcomes as opposed to what is contained in this bill, which really does provide for a tremendous amount of enforcement and compliance. They believe that the type of environment with incentives would achieve more than the highly restrictive public policies that we're seeing within this bill. We heard it from the presenters I've just talked about. As I say, they feel that instead of this highly regulated approach, they believe that there should be more focus on providing incentives.

The Alzheimer Society said this: "Bill 140 is based on a belief that inadequate care can be remedied by inspection and enforcement, but we contend that excellent care can only be encouraged through positive incentives. The bill needs to give more prominence to its provisions for the minister to recognize and reward excellence in all aspects of training, programming and management of long-term-care homes." That's why this would allow the director to actually have the authority to provide incentives to recognize well-run long-term-care homes.

**Ms. Smith:** We also heard from the Ontario Association of CCACs, the Don Mills Foundation for Seniors, the Sherwood Park Manor and, quite eloquently, the Belvedere Heights Home for the Aged in Parry Sound. I would ask Ms. Witmer if she would look at 316, which is the government's amendment. I actually believe that ours, because it provides for regulation-making authority to outline what incentives would be and we also recognize long-term-care homes with an excellent record of compliance with the requirements under the act, is more fulsome and addresses the issue more clearly. I think it's a bit difficult to determine what is a well-run long-term-care home as it's written in motion 315, so I would urge you to consider 316.

**Mrs. Witmer:** What I don't see in 316 is, she or he, the director, can recognize long-term-care homes, but what are they going to do about it? How are they going to recognize them? It doesn't speak to providing incentives. What are they going to do other than recognize them?

**Ms. Smith:** Would you like to articulate what kind of incentives you're proposing?

**Mrs. Witmer:** Well, what is it that you are proposing?

**Ms. Smith:** We're proposing that in regulation we determine how we recognize excellent records of compliance.

**Mrs. Witmer:** So what's going to be different for these people who are recognized to have a clean record or an excellent record of compliance?

**Ms. Smith:** We'll be determining through regulation how we recognize them.

**Mrs. Witmer:** Would you have some suggestion as to how that—

**Ms. Smith:** Well, we certainly heard from Belvedere Heights and from some of the other homes that they would like to see a recognition of the high level of service delivery that they're providing, so some kind of gold-star recognition of our homes that have been without any non-compliance for a certain number of years. We'd be setting out that kind of thing in regulation.

**Mrs. Witmer:** So you're saying it would be more in the way of an award program?

**Ms. Smith:** That's what I anticipate, but again, we haven't started the deliberations on that particular regulation, so we're open to suggestions and ideas. Certainly, we did ask along the way, when homes presented, what they would suggest as a way of recognizing, and we did get some suggestions, but we're open to others.

**Mrs. Witmer:** Well, do you know what? I think it is really important. I do think there were a lot of concerns expressed about the highly regulated nature of this particular piece of legislation. Although there are certainly homes that have not met the compliance requirements, I think it's also fair to say that historically the majority of homes have obviously tried to provide an environment that is in the best interests of their clients: They've tried to comply with the rules and regulations and follow up when recommendations and orders are issued. I hope that we can take a look at this whole issue of continuous quality improvement and try to encourage everybody through best practices to do the best that they can. I hope you will seriously consider the recommendations that might be put forward in the way of incentives that could inspire those who are not performing as well as others to achieve the same type of environment and meet the compliance measures. I think that's important. So I would withdraw this if you're prepared to listen, "you" meaning the ministry.

1410

**Ms. Smith:** You know I'm always prepared to listen. Thank you.

**The Chair:** The motion is withdrawn. That moves us to government motion 316.

**Ms. Smith:** I move that the bill be amended by adding the following section under the heading "Miscellaneous": "Recognition"

"168.1 The director may, in accordance with the regulations, recognize long-term care homes with an excellent record of compliance with the requirements under this act."

To Mrs. Witmer's point, we did hear a great deal about the need for recognition of excellent records. I have visited, in the dozens of homes that I have visited, some that had exceptional records and really are outstanding in the service delivery that they are providing. Through our exception that we had originally drafted to the annual inspection, we are trying to address that. We did hear concerns from some that they wanted to see annual inspections, including those concerns of Ms. Martel, so we have ensured that we are having annual inspections. We also heard concerns that we were not addressing the recognition of good homes well enough by having only a reg-making power. That's why, through this motion 316, we have moved it into the actual body of the legislation while retaining the ability through regulation to actually set out how we will recognize excellent records of compliance.

**Ms. Martel:** Chair, I have no problem with the amendment. Maybe I can just make a suggestion because it follows on the conversation about what could be done.



An awards program is great. You might also want to consider, and this will require incentives and funding—if you have a home that is demonstrating best practices, perhaps, with respect to dealing with residents who suffer from dementia and are doing some exceptional work in that regard, they may require additional financial support to keep that going. You might look at those kinds of things too where people are doing exceptional things with respect to best practices in the care of residents.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is carried.

I would ask, shall sections 169 to 171, inclusive, carry? Carried.

Thus to a new section, 171.1, government motion 317.

**Ms. Smith:** I move that the bill be amended by adding the following section:

“Altering or revoking orders

“171.1 The power to make orders under this act includes the power to alter or revoke such orders from time to time and make others.”

This is to enable the director to have the flexibility to issue a different type of order. If an error is made or if we have achieved partial compliance, but there is a need to issue a different type of order in order to address that partial compliance, they would have the flexibility to do that as well.

**The Chair:** If there is no discussion, those in favour of the motion? Opposed? Carried.

This moves us to NDP motion 318.

**Ms. Martel:** Chair, before I move it, I have a question; I apologize. I think Mrs. Witmer might already have moved an amendment in this regard that appeared somewhere else in the bill. If she did, I'll withdraw it. If she didn't, I'll read it into the record and then you can rule it out of order. I just can't remember if she did.

**Mrs. Witmer:** I did.

**Ms. Martel:** Okay. It's going to be ruled out of order, so I won't go there.

**The Chair:** Okay.

I would ask, shall sections 172 to 175, inclusive, carry? Carried.

Section 176, government motion 319.

**Ms. Smith:** I move that section 176 of the bill be struck out and the following substituted:

“Immunity

“176. No action or other proceeding, other than an application for judicial review under the Judicial Review Procedure Act or any right of appeal or review that is permitted under this act, shall be commenced against the crown, the minister, the director or any employee or agent of the crown for anything done or omitted to be done in good faith in the execution or intended execution of a power or duty under this act.”

This is just to clarify that the judicial review powers under the Judicial Review Procedure Act are still in place and that this section does not preclude any right of appeal as it appears under the act.

**The Chair:** If there is no debate, all those in favour of the motion? Opposed? It is carried.

Shall section 176, as amended, carry? Carried.

That moves us now to section 177, starting with PC motion 320.

**Mrs. Witmer:** I move that section 177 of the bill be amended by adding “or (2.1)” after “subsection (2)” in subsection (1), by striking out “Every” and substituting “Subject to subsection (2.1) every” at the beginning of subsection (2), and by adding the following subsection:

“Exception

“(2.1) Subsection (1) and (2) shall not apply where an individual who is convicted of an offence under this act is an individual member of a board of trustees or directors of a corporation, or an individual member of a board of management for a home under section 123 or 127, or an officer of a corporation, and is convicted solely in that capacity, in which case that individual is liable for a fine of not more than \$1,000 and shall not be subject to imprisonment.”

This is dealing with the penalty issue. As you know, that particular issue caused grave concerns for OANHSS; we also heard about it from the Ontario Long Term Care Physicians, the Don Mills Foundation for Seniors and the regional municipality of Waterloo.

Section 67, combined with section 156, which does not recognize a board's due diligence and the statutory offence provisions in section 177, substantially increased the duties, responsibilities and liabilities of directors and officers of corporations operating long-term-care homes. Section 177 places significant penalties on licensees for failure to comply that actually could result in conviction for a quasi-criminal offence, subject to fines of \$25,000 for a first offence or imprisonment for not more than 12 months, or both. Canadian law, apparently, does not allow insurance policies to cover fines of any kind. Thus, these volunteer directors and anyone who is subject to such fines under this legislation would currently be left to pay these costs. Worse yet, this legislation has the potential for imprisonment for these volunteer directors.

Existing long-term-care legislation does not include offence provisions that impose potential personal liability for directors and officers, so this is new. If you take a look at the Public Hospitals Act, there is a general offence provision relating to contravention of the act and its regulations, but the penalty on conviction is very minor: a fine of not less than \$50 and not more than \$1,000.

So there was a lot of concern about what this might mean unless this amendment was introduced.

We also heard from the doctors, who said this is particularly and disproportionately punitive in nature, in light of the named offences under the act. That's why I've introduced this exception.

**Ms. Smith:** I would ask the members of the committee to look at motions 320, 321, 321.1 and 322. I think we're all singing from the same songbook, more or less. I would note that Mrs. Witmer has attempted to put herself on the side of the angels, but in fact her exception is broader than ours, in that she is including members of boards of trustees and directors of all corporations—“an individual member of a board of management for a

home”—whereas the government and Ms. Martel are limiting the lesser fine requirements to boards of trustees and directors of charitable or non-profit homes and for our members of boards of management.

1420

So I will be moving 321.1. I note that the government has in our motion removed the imprisonment sanctions and reduced the fines to not less than \$50 and up to \$1,000 for those who are directors or officers of a corporation that is the licensee of a non-profit long-term-care home. So we will be going with our motion, which I think is fairly close to Ms. Martel's motion as well.

**Ms. Martel:** Can I just ask a question? My concern had been to deal specifically with municipal homes, non-profit homes and charitable homes. The reference in the government motion to subsection 67(2), as I look at it, goes back to where the licensee is a corporation. Just to be clear, does that mean that people who sit on municipal boards are also covered, so it's not just the officer? By using "corporation" you are capturing those people who are trustees or sit on boards, I'm assuming. Is that correct?

**Ms. Smith:** Yes, we're capturing members of the committee of management.

**Ms. Martel:** And in the case of a not-for-profit home, are they usually a corporation too? I should know that, but I don't; I apologize.

**Ms. Smith:** Yes.

**Ms. Martel:** Okay. So as long as they're captured in there, I'm happy.

**The Chair:** I will call the vote on 320. Those in favour of the motion? Opposed? It is lost.

We now move to government motion 321.

**Ms. Smith:** I want to withdraw 321 and move 321.1.

**The Chair:** Okay. So 321.1 was handed out.

**Ms. Smith:** Yes. I move that section 177 of the bill be amended by adding the following subsection:

"Directors etc.

"(2.1) Despite subsection (1), the following rules apply if an individual is convicted of an offence under this act by virtue of section 67:

"1. If the individual is a member mentioned in subsection 67(2), or a director or officer of a corporation that is the licensee of a non-profit long-term-care home, the individual is liable to a fine of not less than \$50 and not more than \$1,000.

"2. In every other case, the individual is liable to a fine of not more than \$25,000 for a first offence, and not more than \$50,000 for a second or subsequent offence."

**The Chair:** Debate? I will call the vote. Those in favour? Opposed? Carried.

That brings us to NDP motion 322.

**Ms. Martel:** In light of the motion that we have just passed, I will withdraw this motion.

**The Chair:** That brings us to PC motion 323. Ms. Witmer, do you need a moment?

**Mrs. Witmer:** Yes, I do.

I move that subsection 177(5) of the bill be struck out.

This is based on the belief that it's not appropriate to have absolutely no limitation on the time period for prosecution in the long-term-care sector when a reasonable period is afforded to other Ontarians.

**Ms. Smith:** I would note that subsection 177(5) in Bill 140 is exactly the same as the Nursing Homes Act, subsection 36(4), and there are no penalty or limitation provisions under the Charitable Institutions Act or under HARHA. So we think that removing this would place a limitation on the ministry to prosecute that's unacceptable.

**The Chair:** I will call the vote. Sorry; Ms. Witmer?

**Mrs. Witmer:** I want to go back a bit. I want to go back to 177 and the exception that we introduced. There was never an attempt to exempt anybody other than the people in the not-for-profit sector. So I'm not sure where the government—they did make that inference and that was never the intent; that wasn't how we had asked for the motion to be drafted.

**Ms. Smith:** Okay. Just look at motion 320. That's how I read it, so if that wasn't your intent—

**Mrs. Witmer:** No, it was never—

**Ms. Smith:**—"an individual member of a board of trustees or directors of a corporation, or an individual member of a board of management ... under section 123 or 127."

**Mrs. Witmer:** No. Our intent was always based on the input we had received from OANHSS and from the municipalities and the concerns they had. It was the not-for-profit group of people that we were concerned about.

**Ms. Smith:** Okay. Back to 323?

**The Chair:** I will call the vote for 323. Those in favour of the motion? Opposed? The motion is lost.

Shall section 177, as amended, carry? It is carried.

Moving to section 178: government motion 324.

**Ms. Smith:** I move that the French version of subsection 178(1) of the bill be amended by striking out "partie" and substituting "loi."

**The Chair:** Any debate? Those in favour? Opposed? Carried.

Government motion 325?

**Ms. Smith:** I move that subsection 178(2) of the bill be amended by adding the following clause:

"(0.a) respecting the management and operation of long-term care homes."

This is the reg-making power that we moved out of a previous section so that it would apply to the entire legislation, and therefore we have to place it in section 178.

**The Chair:** In favour? Opposed? Carried.

Government motion 326.

**Ms. Smith:** I move that subsection 178(2) of the bill be amended by adding the following clauses:

"(a.1) providing for exceptions to the definition of 'staff' in subsection 2(1);

"(a.2) providing that provisions of this act specified in the regulation do not apply with respect to,

"(i) all persons falling within the definition of 'staff' in subsection 2(1),



“(ii) specified persons or classes of persons falling within that definition.”

**The Chair:** Any debate? In favour? Opposed? Carried.

Next, we've got government motion 327.

**Ms. Smith:** I move that subsection 178(2) of the bill be amended by adding the following clause:

“(c.1) governing the manner of responding to complaints and reports.”

We heard from some of our stakeholders, including the advocacy centre, that they'd like more information about how complaints are responded to and reports on complaints. We need to deal with the confidentiality issue of individuals who are making complaints. So what we've done is create a reg-making power that will allow us to deal with how we will report on complaints back to both the complainant and, if we deem it advisable, to the residents' council or post it in the home. But we want to give ourselves the flexibility to deal with the confidentiality issue.

**The Chair:** In favour of the motion? Opposed? It's carried.

We move next to government motion 327.1, which was distributed.

**Ms. Smith:** I move that subsection 178(2) of the bill be amended by adding the following clause:

“(c.2) defining ‘drug’ for the purposes of this act or for the purposes of any provision of this act.”

Again, we spoke to this yesterday. We needed to move the definition to the end of the legislation so that we could incorporate where it's referred to anywhere, and that's where we took out “pharmaceutical agent” in a number of places because we were going to define it at the end.

**The Chair:** In favour? Opposed? Carried.

That brings us to government motion 328.

**Ms. Smith:** I move that clause 178(2)(k) of the bill be amended by striking out “a resident” in the portion before subclause (i) and substituting “any individual.”

This is just for clarity. As well, this would give us the operational tools to deal with how we report complaints. Again, it deals with the confidentiality of the individual versus the resident, so we want to be able to address that in the regulations.

1430

**The Chair:** Any debate? Those in favour? Opposed? It is carried.

That brings us, still in section 178, to PC motion 329.

**Mrs. Witmer:** In light of our previous discussion, I'm going to be recommending here that clause 178(2)(r) of the bill be struck out.

**The Chair:** Any debate? Those in favour of the motion? Opposed? The motion is carried.

That brings us to government motion 330.

**Ms. Smith:** I move that clause 178(2)(u) of the bill be struck out and the following substituted:

“(u) providing for anything that under this act may or must be provided for or designated in regulations, or that

is to be done in compliance with or in accordance with the regulations.”

This is just adding the words “or designated” to provide for some clarity.

**The Chair:** Any debate? Those in favour? Opposed? It is carried.

Shall section 178, as amended, carry? It is carried.

We have a new section 178.1, PC motion 331.

**Mrs. Witmer:** I move that the bill be amended by adding the following section:

“Public consultation before making regulations

“178.1(1) Subject to subsection (7), the Lieutenant Governor in Council shall not make any regulation under this act unless,

“(a) the minister has published a notice of the proposed regulation in the Ontario Gazette and given notice of the proposed regulation by all other means that the minister considers appropriate for the purpose of providing notice to the persons and entities who may be affected by the proposed regulation;

“(b) the notice complies with the requirements of this section;

“(c) the time periods specified in the notice, during which persons may make comments under subsection (2) have expired;

“(d) the minister has considered whatever comments that persons have made on the proposed regulation in accordance with subsection (2) or an accurate synopsis of the comments; and

“(e) the minister has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the minister considers appropriate.

“Contents of notice

“(2) The notice mentioned in clause (1)(a) shall contain,

“(a) a description of the proposed regulation and the text of it;

“(b) a statement of the time period during which any person may submit written comments on the proposed regulation to the minister and the manner in which and the address to which the comments must be submitted;

“(c) a statement of where and when any person may review written information, if any, about the proposed regulation; and

“(d) all other information that the minister considers appropriate.

“Time period for comments

“(3) The time period mentioned in clause (2)(b) shall be at least 60 days after the minister gives the notice mentioned in clause (1)(a) unless the minister shortens the time period in accordance with subsection (4).

“Shorter time period for comments

“(4) The minister may shorten the time period if, in the minister's opinion,

“(a) the urgency of the situation requires it;

“(b) the proposed regulation clarifies the intent or operation of this act or the regulations made under it; or

“(c) the proposed regulation is of a minor or technical nature.

"Discretion to make regulations

"(5) Upon receiving the minister's report mentioned in clause (1)(e), the Lieutenant Governor in Council, without further notice under subsection (1), may make the proposed regulation with the changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the minister's report.

"No public consultation

"(6) The minister may decide that subsections (1), (2), (3), (4) and (5) should not apply to the power to make a regulation under this act if, in the minister's opinion,

"(a) the urgency of the situation requires it;

"(b) the proposed regulation clarifies the intent or operation of this act or the regulations made under it; or

"(c) the proposed regulation is of a minor or technical nature.

"Notice

"(7) If the minister decides that subsections (1), (2), (3), (4) and (5) should not apply to the power to make a regulation under this act,

"(a) those subsections do not apply to the power to make the regulation; and

"(b) the minister shall give notice of the decision to the public as soon as is reasonably possible after making the decision.

"Contents of notice

"(8) The notice mentioned in clause (7)(b) shall include a statement of the minister's reasons for making the decision and all other information that the minister considers appropriate.

"Publication of notice

"(9) The minister shall publish the notice mentioned in clause (7)(b) in the Ontario Gazette and give the notice by all other means that the minister considers appropriate.

"No review

"(10) Subject to subsection (11), no court shall review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section.

"Exception

"(11) Any person resident in Ontario may make an application for judicial review under the Judicial Review Procedure Act on the grounds that the minister has not taken a step required by this section.

"Time for application

"(12) No person shall make an application under subsection (11) with respect to a regulation later than 21 days after the day on which the minister publishes a notice with respect to the regulation under clause (1)(a) or subsection (9), if applicable."

This wording is to a large degree based on the legislation that was contained within the LHIN legislation.

**The Chair:** Debate?

**Ms. Smith:** I would note that motions 331, 332 and 332.1 all deal with the same issue. I believe that Ms. Martel's is very similar to 331. I would point out that our 332.1 is the government motion. It differs in a couple of ways, and I think, for the purposes of time management,

I'll just go through what our changes are, and then we can talk about the notion.

The changes are with respect to 178.1(1)(a), that "the minister has published a notice of the proposed regulation on the website of the ministry and in any other format the minister considers advisable." So we're not putting the Gazette provision there because our experience has been that most people go to the website; very few people would start at the Gazette.

We have merged clause (d) and (e) into clause (d). The time period for comment we have limited to 30 days as opposed to 60 days in subsection (3). In subsection (9), we again reference only the website, not the Gazette. In subsection (10), we have reworded "a court shall not review any action," which is very similar; it's the same concept, just a different wording. And we have added section 178.2: "(1) The minister may decide that the procedures set out in section 178.1 shall apply to a regulation that is not the initial regulation with respect to a matter if the minister decides that it is advisable in the public interest to do so, and in such a case section 178.1 applies with necessary modifications."

What we're trying to do here is that on the first round of regulations we would go through this process, but for subsequent regulation changes we may or may not take the same process. It's to give the ministry some flexibility to move forward on amendments that happen on a regular basis without having to go through the whole consultation process.

I know that Ms. Witmer and Ms. Martel are both pretty familiar with the long-term-care regime. On an annual basis, we look at copay; we do some other regulation changes that would be considered part of the routine matters of managing the system. I think if the minister felt that there was a change that was going to be substantial, it would be in his discretion to invoke section 178.1, but on the regular day-to-day activity of long-term care, we could do a shorter process for amending a regulation. So that's why we've included section 178.2.

That will be the government's position on how we want to move forward. We did make a commitment during the hearings that we would be doing public consultations on the regulations arising out of this legislation, so I think we're *ad idem* on pretty much everything except for those few things that I've just mentioned.

**The Chair:** Ms. Witmer?

1440

**Mrs. Witmer:** I think what people were most looking for was the opportunity to participate and be consulted in the development of the regulations, so that there could be very thoughtful consideration given to how this was going to apply to putting them into practice. I think it is also an opportunity for the government, because of what we've heard is a somewhat heavy-handed approach to this legislation, in some respects, with a lot of new paper and requirements, and working together in the regulation-making with the parties who are interested hopefully could foster some trust and co-operation in moving for-



ward. Also, I know the government speaks in the preamble to collaboration.

Why have you gone from 60 to 30 days? In the other legislation we allowed for 60 days.

**Ms. Smith:** There are different times in different pieces of legislation. Some have used 60, some have used 30. I was told that 30 is more manageable as far as moving things forward. There has been, as you well know, quite a bit of pressure to get this legislation in place and moving forward, and I think that we want to continue to move things forward as quickly as we can. I think 30 days does allow for those involved in the sector to respond to any possible amendments or regulations.

**Mrs. Witmer:** When do you see this process of consultation on the regulations taking place? What's the timeline that's anticipated?

**Ms. Smith:** I don't have a timeline before me today. Obviously, as we've gone through it, there are a lot of regulations to be drafted. We have started working on regulations. I don't anticipate that we would wait until we had them all to go forward, but that we would start with some and start the process. Am I right?

*Interjection.*

**Ms. Smith:** Yes. We have been working on regulations, so I anticipate that we'd be moving forward fairly quickly with the first batch.

**Ms. Martel:** I just had a question, just to be sure about 178.2(1). I'm assuming that it is the addition of the words "not the initial regulation" which makes it clear that all the regulations that flow from this bill will follow the process that's outlined. Those are the key words that make the distinction between what's coming from this bill, which should be new, versus other regulations that may already be in place that are being amended.

**Ms. Smith:** Sorry, Ms. Martel.

**Ms. Martel:** That's okay. I think this is correct, but I just want to be clear that the distinction between what's coming from this bill and where you have regulations that may already be in place that you amend from time to time is around the words "the initial regulation."

**Ms. Smith:** Yes, "The initial regulation with respect to a matter...."

**Ms. Martel:** Okay, so we assume that what is coming from here is new for the first time and will be dealt with under the process that we're going to agree to.

**Ms. Smith:** Yes, and then it's the minister's discretion on others.

I would also just point out to Mrs. Witmer that what we've said is, "Shall be at least 30 days." So if there's a particular issue where we think that a longer consultation period would be appropriate, we've allowed ourselves the flexibility to go with a longer period, but at least 30 days.

**The Chair:** Shall I call the vote on 331?

**Mrs. Witmer:** I would withdraw my motion.

**The Chair:** Motion 331 is withdrawn. That brings us to NDP motion 332.

**Ms. Martel:** I'll withdraw that, Chair.

**The Chair:** That is withdrawn.

That brings us to government motion 332.1.

**Mrs. Jeffrey:** I move that the bill be amended by adding the following sections:

"Public consultation before making initial regulations

"178.1(1) The Lieutenant Governor in Council shall not make the initial regulation with respect to any matter about which the Lieutenant Governor in Council may make regulations under this act unless,

"(a) the minister has published a notice of the proposed regulation on the website of the ministry and in any other format the minister considers advisable;

"(b) the notice complies with the requirements of this section;

"(c) the time periods specified in the notice, during which members of the public may exercise a right described in clause (2)(b) or (c), have expired; and

"(d) the minister has considered whatever comments and submissions that members of the public have made on the proposed regulation in accordance with clause (2)(b) or (c) and has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the minister considers appropriate.

"Contents of notice

"(2) The notice mentioned in clause(1)(a) shall contain,

"(a) a description of the proposed regulation and the text of it;

"(b) a statement of the time period during which members of the public may submit written comments on the proposed regulation to the minister and the manner in which and the address to which the comments must be submitted;

"(c) a description of whatever other rights, in addition to the right described in clause (b), that members of the public have to make submissions on the proposed regulation and the manner in which and the time period during which those rights must be exercised;

"(d) a statement of where and when members of the public may review written information about the proposed regulation; and

"(e) all other information that the minister considers appropriate.

"Time period for comments

"(3) The time period mentioned in clauses (2)(b) and (c) shall be at least 30 days after the minister gives the notice mentioned in clause (1)(a) unless the minister shortens the time period in accordance with subsection (4).

"Shorter time period for comments

"(4) The minister may shorten the time period if, in the minister's opinion,

"(a) the urgency of the situation requires it;

"(b) the proposed regulation clarifies the intent or operation of this act or the regulations; or

"(c) the proposed regulation is of a minor or technical nature.

"Discretion to make regulations

"(5) Upon receiving the minister's report mentioned in clause (1)(d), the Lieutenant Governor in Council, without further notice under subsection (1), may make the

proposed regulation with the changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the minister's report.

"No public consultation

"(6) The minister may decide that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under this act if, in the minister's opinion,

"(a) the urgency of the situation requires it;

"(b) the proposed regulation clarifies the intent or operation of this act or the regulations; or

"(c) the proposed regulation is of a minor or technical nature.

"Same

"(7) If the minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under this act,

"(a) those subsections do not apply to the power of the Lieutenant Governor in Council to make the regulation; and

"(b) the minister shall give notice of the decision to the public as soon as is reasonably possible after making the decision.

"Contents of notice

"(8) The notice mentioned in clause (7)(b) shall include a statement of the minister's reasons for making the decision and all other information that the minister considers appropriate.

"Publication of notice

"(9) The minister shall publish the notice mentioned in clause (7)(b) on the website of the ministry and give the notice by all other means that the minister considers appropriate.

"No review

"(10) Subject to subsection (11), a court shall not review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section.

"Exception

"(11) Any person resident in Ontario may make an application for judicial review under the Judicial Review Procedure Act on the grounds that the minister has not taken a step required by this section.

"Time for application

"(12) No person shall make an application under subsection (11) with respect to a regulation later than 21 days after the day on which the minister publishes a notice with respect to the regulation under clause (1)(a) or subsection (9), if applicable.

"Amendments

"178.2(1) The minister may decide that the procedures set out in section 178.1 shall apply to a regulation that is not the initial regulation with respect to a matter if the minister decides that it is advisable in the public interest to do so, and in such a case section 178.1 applies with necessary modification.

"No review

"(2) A court shall not review any decision by the minister under this section as to whether or not to make

the procedures set out in section 178.1 apply to a regulation."

**The Chair:** Thank you. We have in a sense debated this already. Any additional debate? I will call the vote. Those in favour? Opposed? It is carried.

Shall section 179 carry? Carried.

We move now to section 180 with government motion 333.

**1450**

**Mr. Peter Fonseca (Mississauga East):** I move that paragraphs 1, 2, 3, 4 and 6 of subsection 180(3) of the bill be struck out and the following substituted:

"1. For a home with new beds, the term shall be 25 years starting on the day the first resident was admitted to a new bed or, for one of the following homes, the term shall be 25 years starting on the day the first resident was admitted to the home, but in no event shall the term be less than 20 years from the date this paragraph comes into operation:

"i. Billings Court Manor (Burlington),

"ii. Millennium Trail Manor (Niagara Falls),

"iii. St. Joseph's Health Centre (Guelph),

"iv. St. Joseph's Mother House (Martha Wing) (Hamilton).

"2. For a home with class A beds, the term shall be 20 years starting on the day this section comes into operation.

"3. For a home with class B beds, the term shall be 15 years starting on the day this section comes into operation.

"4. For a home with class C beds, the term shall be 15 years starting on the day this section comes into operation....

"6. For a home with class D beds that were not upgraded in accordance with the upgrade option guidelines, the term shall be four years starting on the day this section comes into operation."

**Mr. Leal:** Mr. Chair, can I ask for a recorded vote on this one?

**The Chair:** Yes. Debate?

**Ms. Smith:** The changes in the listings of the homes is just a correction to ensure that we are listing the appropriate name of a home—Millennium Trail Manor as opposed to Oakville Park Lodge. We wanted to ensure that our newer homes, which opened early on in the process of new homes, had at least a 20-year licence because the licence term that we are determining starts from the time the first resident has entered the home. In some cases, some of our newer homes have been open for seven years. The 25-year licence would have started running and they'd only have 18 left, so we're ensuring that they have 20, which is why we have that provision. We've also lengthened the terms for all of the other types of homes, as was requested by the OLTCA, except with respect to homes that have two types of classifications. We haven't gone with the OLTCA recommendations in those cases.

**Ms. Martel:** I don't think it will be a surprise, given the comments I made about section 100, that I will not be



supporting this particular section that sets out the different fixed terms. Section 100 set out the provision to have a licence with a fixed term in the first place. This particular section then outlines what those terms will be, depending on the category of bed. I put forward a position that had been put forward to the government by OANHSS, which essentially said, as I said before, that homes continue to have licences; that there was not a history of homes not responding when the government provided funding to redo the D beds. The overwhelming majority did.

If the government has very specific concerns with respect to a specific home, I think they can deal with that under subsection 99(1), which says, "A licence is subject to the conditions, if any, that are provided for in the regulations." I think the real issue here is a capital development project, which I hope the government is going to come forward with. I feel very confident that if they did, operators would step up to the plate, just as people who were redoing D homes did.

Finally, I just want to again in this section raise the concerns that we heard specifically from smaller homes in rural areas and not-for-profit homes about the conversations that some of them have already had with lending institutions that they have a relationship with, which have indicated to them that these provisions would present a greater risk to the financial institution and therefore would require greater payments, if indeed these homes can even find the money to move forward without government support. I am not really interested in giving the banks any more money than they already have. So as with section 100, my concerns apply to this particular section because of the actual terms of the licence based on the category of the homes as set out in this specific section.

**Mrs. Witmer:** This motion certainly does not in any way, shape or form address the concerns that were expressed to us. The issue is the whole issue of the licensing terms. This simply speaks to the length of the licensing term. The reality is, and Ms. Martel has spoken to it, regardless of the time and based on the fact that a home can be closed down at any time without any reason needing to be provided, it's creating uncertainty. People aren't going to be able to get financing. In fact, they're going to find it increasingly difficult to do any upgrading or any renovations. The government is not willing to commit to any capital renewal plan. I'll tell you, the very future of this sector, particularly the small homes, is threatened. So I can't support this, because it isn't providing the certainty and it isn't going to allow for capital funding to be provided to the homes in order that they can rebuild them, that they can get rid of the three- and four-bed wards, that they can build homes or renovate homes to make them totally wheelchair-accessible. So this motion is totally inadequate.

**The Chair:** Any other discussion? I will call the vote. Those in favour of the motion?

**Mr. Leal:** Recorded, Mr. Chair.

**The Chair:** Correct; a recorded vote was requested.

## Ayes

Fonseca, Jeffrey, Leal, Ramal, Smith.

## Nays

Martel, Witmer.

**The Chair:** The motion is carried.

That brings us to PC motion 334.

**Mrs. Witmer:** Based on what has just been passed, I would withdraw this motion, because the government has already made their decision as to how they're going to move forward in this regard.

**The Chair:** That brings us to NDP motion 335.

**Ms. Martel:** I move that subsection 180(3) of the bill be struck out.

I won't go through the arguments that I already made, both with respect to section 100 and comments that I just made around the government's amendment in this section.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is lost.

Government motion 336.

**Ms. Smith:** Motion 336 is withdrawn; to 336.1.

**The Chair:** Motion 336.1 has been distributed separately.

**Ms. Smith:** I move that section 180 of the bill be amended by adding the following subsections:

"Special rule for homes that have provided notice

"(3.1) Despite subsection (3) or anything else in this section to the contrary, if an approved corporation operating an approved charitable home for the aged under the Charitable Institutions Act has provided notice to the ministry on or before February 1, 2007 of its intention to close the home, the approved corporation shall receive a temporary licence under section 110.

"Special rule for homes under development at the time of proclamation

"(3.2) Despite subsection (3) or anything else in this section to the contrary, any long-term care home that is being developed and has not yet opened as of the date this section comes into operation shall be deemed to receive a term equal in duration to such term the home would have received had it been developed and opened on the date subsection (3) comes into operation."

The second amendment is to deal with those homes where we've put out an RFP and we anticipate they will be in the process of being built when this comes into force, and the first is to deal with a couple of situations where we've had notice from homes of their intention to look at winding down, and we need to be able to address that with a temporary licence.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? Carried.

Still on section 180, government motion 337.

**Mr. Leal:** I move that subsection 180(4) of the bill be amended by striking out "or" at the end of clause (a) and by adding the following clauses:

“(c) paragraphs 2 and 3 of subsection (3) apply to a home, in which case the term for that home shall be 15 years or such other term as one of the homes would be entitled to under paragraph 2 or 3, whichever is shorter, and shall start on the day this section comes into operation; or

“(d) paragraphs 2 and 4 of subsection (3) apply to a home, in which case the term for that home shall be 15 years or such other term as one of the homes would be entitled to under paragraph 2 or 4, whichever is shorter, and shall start on the day this section comes into operation.”

1500

**The Chair:** Debate?

**Ms. Smith:** This is just in order to deal with those homes that have different classifications of construction; some are B and A and C and A. This provides for more certainty as to what licence term those types of homes will be receiving.

**The Chair:** Any other debate? I'll call the vote. Those in favour? Opposed? Number 337 is carried.

That brings us to PC motion 338.

**Mrs. Witmer:** Based on the government's moving of the previous motion, I would withdraw this one since they've made a decision.

**The Chair:** That brings us to government motion 339.

**Mrs. Jeffrey:** I move that subsection 180(5) of the bill be struck out and the following substituted:

“Special rule for homes with class D beds that were not upgraded, if agreement

“(5) If the licensee of a home described in paragraph 6 of subsection (3) agrees, during the first year of the four-year term set out in that paragraph, to redevelop the home to the current standards to the satisfaction of the director, the director shall give an undertaking under section 98 that he or she will issue a new licence under section 97 to the licensee after the redevelopment is completed, and the director may, despite clause 112(2)(b), extend the four-year term for such additional time that the director considers sufficient to complete the redevelopment.”

**The Chair:** Debate?

**Ms. Smith:** Both this one and motion 340 are in order to deal with the last few homes that have D classifications and in order to allow for the completion of the redevelopment of those homes if the homes so choose.

**The Chair:** Those in favour of the motion? Opposed? Carried.

That brings us now to 340. Motion 340 has been withdrawn.

**Ms. Smith:** No.

**The Chair:** Motion 340 stands?

**Ms. Smith:** Yes.

**Mr. Ramal:** I move that subsection 180(7) of the bill be struck out and the following substituted:

“Special rule for homes with class D beds that were not upgraded, if no agreement

“(7) If the licensee of a home described in paragraph 6 of subsection (3)”—

**Ms. Smith:** Sorry, Chair; my mistake. Motion 340 was being withdrawn. It's 340.1 that should be considered. You were right and I was wrong.

**The Chair:** I suspected that.

**Ms. Smith:** I apologize.

**The Chair:** So 340 is withdrawn; 340.1. I've always believed I'm not as stupid as I look.

**Mr. Ramal:** I move that subsection 180(7) of the bill be struck out and the following substituted:

“Special rule for homes with class D beds that were not upgraded, if no agreement

“(7) If the licensee of a home described in paragraph 6 of subsection (3) does not agree, during the first year of the four-year term, to redevelop the home to the current standards and to the satisfaction of the director, the director shall be deemed to have given notice to the licensee under clause 101(1)(a) that no new licence will be issued.”

**The Chair:** Any discussion? Those in favour of the motion? Opposed? It is carried.

Shall section 180, as amended, carry? It is carried.

We now move to section 180.1, which is new: PC motion 341.

**Mrs. Witmer:** I move that the bill be amended by adding the following section:

“Initial review

“180.1(1) Within five years of proclamation of this act, the minister shall appoint a review committee of no less than three persons to review the operation of this act and the regulations and to make recommendations to the minister concerning amendments and other matters.

“Time for review

“(2) The review committee shall complete its review and make recommendations to the minister within 18 months of its appointment.

“Committee composition

“(3) The review committee shall include at least one representative from each of the for-profit, non-profit and municipal long-term care home licensee sectors.

“Subsequent review

“(4) The minister shall, no later than five years after the appointment under subsection (1), appoint a committee to conduct a subsequent review and shall, no later than five years after the most recent appointment under this subsection, appoint committees to conduct subsequent reviews.”

This was a point that was brought to our attention and OANHSS was one of the individual groups that did recommend, I guess in light of the extensive requirements and regulations and changes that you're making to the whole long-term-care sector, that there should be a provision included to ensure that there would be a review of the effectiveness of this act after it has been in operation for a period of time, in this case five years.

Also, I would hasten to add that this type of sunset provision is very consistent with other complex legislation that this government has introduced, such as the Local Health System Integration Act, 2006, and the Personal Health Information Protection Act, 2004.



**The Chair:** If there's no debate—Ms. Smith?

**Ms. Smith:** Just a very quick comment. We have been very sensitive to those sections of the act that would require a change over time and have thus attempted to address those in regulation more than in the actual legislation. So I don't feel that a review in five years is necessary. I don't believe that it is the same type of legislation as the LHIN legislation, which is new and introduces a whole new concept to our health care. This is an amalgamation of three into one, and I think we have included a great deal of flexibility in our reg-making ability to deal with anything that may come up that needs to be addressed.

**The Chair:** Ms. Martel?

**Ms. Martel:** My amendment number 343 is the same as Mrs. Witmer's and I agree with her.

**The Chair:** I will call the vote. Those in favour of the motion?

**Mrs. Witmer:** I would have a recorded vote.

**The Chair:** A recorded vote.

#### Ayes

Martel, Witmer.

#### Nays

Fonseca, Jeffrey, Leal, Ramal, Smith.

**The Chair:** The motion is lost.

That brings us to NDP motion 342.

**Ms. Martel:** I move that the bill be amended by adding the following section:

"Education

"180.1 The ministry shall provide funding to develop and implement education to assist the long-term care homes, residents, families and ministry staff in understanding and applying the new legislative requirements such that all parties have consistent clarity on those requirements and their part in meeting them."

**The Chair:** The motion is out of order.  
NDP motion 343.

**Ms. Martel:** Chair, it's the same as that put by Mrs. Witmer, which we've already voted on, so I will withdraw it.

**The Chair:** Shall sections 181 to 185, inclusive, carry? They are carried.

Prior to voting on section 186, I would ask if there is any debate.

**Mrs. Witmer:** No. I would simply say that our recommendation would be to vote against section 186.

**The Chair:** I will call the vote. Shall section 186 carry? It is carried.

Moving to section 186.1, which is new: NDP motion 345.

**Ms. Martel:** I move that part X of the bill be amended by adding the following section:

"Review of funding system

"186.1 Within one year of the day this act received royal assent, the ministry shall revise the funding system for long-term care homes."

**The Chair:** Any additional debate?

**Ms. Martel:** Actually, this recommendation comes from the coroner's jury that looked into the deaths at Casa Verde. It was recommendation 26. The coroner's jury did extensive work and heard from many people over many days of testimony. I think this is an important recommendation because they made it clear that changes in funding were required, and even at the time of publishing their recommendations, they said within one year. We are beyond that period, but if recognized that we are dealing with this particular bill, it would be appropriate to deal with it in this bill and say that one year after, the government should be in a position to revise the funding system for long-term-care homes in the province.

1510

**The Chair:** Okay. Any addition to the discussion?

**Ms. Smith:** Yes. We don't believe that it would be appropriate to include this kind of provision in the legislation. It really doesn't deal with the governing of our long-term-care homes. It deals with the system, and there's nothing that would require legislative authority to do a funding system review. It can be determined through policy, and I know that through the Casa Verde recommendations the ministry is aware that there has been a request made for that kind of review. Actually, if you read my report, Commitment to Care, I talk about a review of the funding system in long-term care, so it can be addressed in policy.

**The Chair:** Any additional debate?

I'll call the vote on motion 345. Those in favour? Those opposed? The motion is lost.

NDP motion 346.

**Ms. Martel:** I move that part X of the bill be amended by adding the following section:

"Review of funding system

"186.2 Within one year of the day this act receives royal assent, the ministry shall commission an independent consultant to conduct a thorough and evidence-based report on the appropriate staffing levels for long-term care facilities in Ontario."

This flows out of the Casa Verde recommendations as well, from the coroner's jury, where they specifically talked about the need to update the PricewaterhouseCoopers study that had been done, and once that was done, to then move to a system where levels of care of residents would be met. This follows up on the number of recommendations they made which speak to the need to have that work done again so that we have a very good system on which to base staffing levels.

I've also argued that very clearly we should have 3.5, because I think you'd find after you did a thorough review that it's probably going to be even higher than that, so I think 3.5 should be what we have in place right now. But I also think that doing the report would support that and would probably show a need for even greater

levels of care, given the frail nature of those who are coming into long-term-care homes as residents.

**The Chair:** Any other debate?

**Ms. Smith:** The ministry presently has the discretion to undertake such a cut study and I don't think it's appropriate to include this in legislation.

**The Chair:** I'll call the vote. Those in favour of the motion? Those opposed? The motion is lost.

Shall section 187 carry? Carried.

That moves us next to section 188, government motion 347.

**Mr. Fonseca:** I move that subsection 188(5) of the bill be struck out and the following substituted:

"(5) Subparagraph 8 iii of subsection 55(1) of this act is repealed and the following substituted:

"iii. the financial statements relating to the home filed with the director under the regulations or provided to a local health integration network, and."

**The Chair:** Any debate?

**Ms. Smith:** This amendment and a number of the subsequent amendments are a result of the local health integration network legislation that was passed. We need to incorporate that language into the legislation.

**The Chair:** Those in favour of the motion? Opposed? It is carried.

Still on the same section, government motion 348.

**Mrs. Jeffrey:** I move that section 188 of the bill be amended by adding the following subsections:

"(10.1) Subsection 88(4) of this act is amended by adding 'including a local health integration network' after 'crown.'

"(10.2) Subsection 99(3) of this act is repealed and the following substituted:

"Conditions of licence

"(3) It is a condition of every licence that the licensee shall comply with this act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this act and those acts."

**The Chair:** Any discussion? I'll call the vote. Those in favour? Opposed? Carried.

Government motion 349.

**Mr. Leal:** I move that section 188 of the bill be amended by adding the following subsections:

"(17) Subsection 160(6) of this act is repealed and the following substituted:

"Notice of decision

"(6) The director shall serve the following with notice of the director's decision, which shall include reasons if the order is confirmed or altered:

"1. The licensee.

"2. The local health integration network that provides funding under the Local Health System Integration Act, 2006, to the licensee, in respect of a decision that relates to an order made under section 151.

"(18) Section 164 of this act is repealed and the following substituted:

"Parties

"164. The parties to an appeal are,

"(a) the licensee;

"(b) the director; and

"(c) in the case of an appeal from an order made under section 152, the local health integration network that provides funding under the Local Health System Integration Act, 2006, to the licensee.

"(19) Section 176 of this act repealed and the following substituted:

"Immunity

"176. No action or other proceeding, other than an application for judicial review under the Judicial Review Procedure Act or any right of appeal or review that is permitted under this act, shall be commenced against the crown, the minister, the director or any employee or agent of the crown, including a local health integration network, or any officer, director or employee of a local health integration network, for anything done or omitted to be done in good faith in the execution or intended execution of a power or duty under this act."

**The Chair:** Any debate? I'll call the vote. Those in favour of the motion? Opposed? It is carried.

Shall section 188, as amended, carry? It is carried.

Shall sections 189 to 199 carry? Carried.

That brings us to section 200 and government motion 350.

**Mr. Ramal:** I move that subsection 200(3) of the bill be struck out and the following substituted:

"(3) The definition of 'crisis' in section 39 of the act is repealed and the following substituted:

"'crisis' means a situation prescribed by the regulations as a crisis; ('crise')"

**The Chair:** Any discussion? Those in favour of the motion? Opposed? It is carried.

Government motion 351.

**Mr. Fonseca:** I move that subsection 200(4) of the bill be struck out and the following substituted:

"(4) Section 39 of the act is amended by adding the following definition:

"'secure unit' means a secure unit within the meaning of the Long-Term Care Homes Act, 2007; ('unité de sécurité')"

**Ms. Smith:** This is just to ensure that we have consistency between the Health Care Consent Act and the Long-Term Care Homes Act, which we're amending.

**Ms. Martel:** I think I missed that. I thought it meant that because we had provided a definition for "secure unit"—maybe we didn't, because it was a long time ago that we did the definitions section—you were making sure it complied with the definition in the definitions section. Is that what this is?

**Ms. Smith:** Sorry, no. We're actually amending section 39 of the Health Care Consent Act. So this is a subsequent amendment, through the Long-Term Care Homes Act, to amend the Health Care Consent Act in order to ensure that "secure unit," as we define it, is how they define it.

1520

**The Chair:** Okay. Shall I call the vote on 351? All in favour of the motion? Opposed? Carried.

Motion 352.



**Mrs. Jeffrey:** I move that section 200 of the bill be amended by adding the following subsection:

“(8.1) Subsection 47(2) of the act is repealed and the following substituted:

“Consent or refusal to be obtained

“(2) When an admission to a care facility is authorized under subsection (1), the person responsible for authorizing admissions to the care facility shall obtain consent, or refusal of consent, from the incapable person’s substitute decision-maker promptly after the person’s admission.”

**The Chair:** Thank you. I have some question whether this motion is in order given that section 47 of the Health Care Consent Act is not open.

**Ms. Smith:** Mr. Chair, we believe that this amendment is required to rectify an inconsistency that would otherwise result in the restraint admission in the secure unit provisions of Bill 140. Consent is required before admission or transfer to a secure unit and before admission to a long-term-care home by either the person or the person’s substitute decision-maker. I think in order to have the consistency between our legislation and the Health Care Consent Act, we need to be able to address that through this amendment. Do we need all-party agreement to open that section of the Health Care Consent Act?

**The Chair:** No.

**Ms. Smith:** Do you want all my legal reasons why this is appropriate?

*Interjections.*

**Ms. Smith:** No, the other ones were already opened by the legislation.

**The Chair:** The question is, if we don’t do this amendment, is either one of the bills now technically flawed?

**Ms. Smith:** Is either one of the bills—sorry?

**The Chair:** Technically flawed.

**Ms. Smith:** The amendment is required, otherwise we will have inconsistency between the two pieces of legislation, yes.

**The Chair:** I am going to accept this amendment. Okay. Debate?

**Ms. Smith:** I think we’ve pretty much covered it.

**The Chair:** I will call the vote. All those in favour? Opposed? It is carried.

Shall section 200, as amended, carry? Carried.

Shall sections 201 and 202 carry? Carried.

That brings us to section 203.

**Mr. Ramal:** I move that section 203 of the bill be amended by adding the following subsections:

“(2) Subsections (3) and (4) apply only if Bill 171 (Health System Improvements Act, 2006), introduced on December 12, 2006, receives royal assent.

“(3) References in subsection (4) to provisions of Bill 171 or to provisions of the Health Protection and Promotion Act mentioned in that bill are references to those provisions as they were numbered in the first reading version of the bill.

“(4) On the later of the day this subsection comes into force and the day that section 14 of schedule F to Bill 171 comes into force, paragraphs 2 and 10 of the definition of ‘health care provider or health care entity’ in subsection 77.7 (5) of the Health Protection and Promotion Act are repealed and the following substituted:

“2. A service provider within the meaning of the Home Care and Community Services Act, 1994 who provides a community service to which that act applies....

“10. A long-term care home under the Long-Term Care Homes Act, 2007.”

**The Chair:** This amendment is out of order.

**Mr. Ramal:** Why didn’t you tell me at the beginning, Mr. Chair?

**The Chair:** It has to be read first. I’m sorry.

**Mr. Ramal:** I’m joking.

**The Chair:** You did a great job, but it is out of order. That section is not open at this time.

Shall section 203 carry? Carried.

Shall sections 204 to 206 carry? Carried.

Section 207, government motion 354.

**Mr. Fonseca:** I move that subsection 207(4) of the bill be struck out and the following substituted:

“(4) Clause 28(3)(c) of the act is repealed and the following substituted:

“(c) issue an order under paragraph 1 of that subsection, in respect of the operation of a long-term care home, to a health service provider described in paragraph 4 of the definition of ‘health service provider’ in subsection 2(2), if the service provider is also described in another paragraph of that definition.”

**The Chair:** Any debate?

**Ms. Smith:** This is another consequential amendment dealing with the Local Health System Integration Act.

**The Chair:** I will call the vote. Those in favour? Opposed? It is carried.

Shall section 207, as amended, carry? Carried.

Shall sections 208 to 210 carry? Carried.

That brings us to section 211, government motion 355.

**Mr. Leal:** I move that subsections 211(5), (6), (7), (8), (9) and (10) of the bill be struck out and the following substituted:

“(5) Clause (c) of the definition of ‘local board’ in subsection 10(6) of the act is amended by striking out ‘Homes for the Aged and Rest Homes Act’ and substituting ‘Long-Term Care Homes Act, 2007’.

“(6) The definition of ‘lodging house’ in section 11.1 of the act is repealed and the following substituted:

“‘lodging house’ means any house or other building or portion of it in which persons are lodged for hire, but does not include a hotel, hospital, long-term care home, home for the young or institution if it is licensed, approved or supervised under any other act; (‘pension’)

“(7) Clause 216(3)(c) of the act is amended by striking out ‘Homes for the Aged and Rest Homes Act’ and substituting ‘Long-Term Care Homes Act, 2007’.

“(8) Clause (c) of the definition of ‘local board’ in section 223.1 of the act is amended by striking out ‘Homes

for the Aged and Rest Homes Act' and substituting 'Long-Term Care Homes Act, 2007'."

**The Chair:** Any debate?

**Ms. Smith:** These are just technical amendments to reflect the changes to the Municipal Act.

**The Chair:** Ms. Martel?

**Ms. Martel:** What's the reference to the Municipal Act? I understand that's the act under change, but is it around something to do with the lodging house, something you have to have these other amendments—

**Ms. Smith:** It has to do with the fact that we refer to the Homes for the Aged and Rest Homes Act, and so now we have to reference the Long-Term Care Homes Act.

**Ms. Martel:** Got it.

**The Chair:** I will call the vote. Those in favour? Opposed? Carried.

Shall section 211, as amended, carry? It's carried.

Shall sections 212 to 215 carry? Carried.

That brings us now to section 216, government motion 356.

**Mrs. Jeffrey:** I move that subsection 216(2) of the bill be amended by adding "and Long-Term Care" after "Health."

**The Chair:** Good. I will call the vote. Those in favour? Opposed? Carried.

Shall section 216, as amended, carry? Carried.

I will ask, shall sections 217 to 226 carry? Carried.

That brings us next to the preamble, government motion 357.

1530

**Ms. Smith:** Mr. Chair, I understand that we have all-party agreement to deal with the preamble and look at amendments to the preamble.

**The Chair:** Okay, if you will move it first and then ask for unanimous consent.

**Ms. Smith:** I'm actually withdrawing 357 and I will be moving 361. I will leave it to my colleague.

**The Chair:** Motion 357 is withdrawn, bringing us to PC motion 358.

**Mrs. Witmer:** I move that the preamble to the bill be struck out and the following substituted:

"The people of Ontario, government and licensees of long-term-care homes believe in resident-centred care;

"Remain committed to the provision of care and, the health and well-being of Ontarians living in long-term care homes now and in the future;

"Strongly support collaboration amongst residents, their families and friends, licensees, service providers, caregivers, volunteers, the community and governments to ensure that the care and services are provided to meet the needs of the resident;

"Recognize the principle of providing adequate funding based on assessed needs of residents.

"Recognize that access to community based health care including the care provided in long-term care homes based on assessed need is a cornerstone of an effective health care system;

"Recognize the principle of a common vision of shared responsibility;

"Firmly believe in public accountability and transparency to demonstrate that long-term care homes are funded, governed and operated in a way that reflects the interest of the public, and promotes effective and efficient delivery of high-quality services.

"Firmly believe in clear and consistent standards of care and services, supported by a strong, fair and consistent compliance, inspection and enforcement system;

"Recognize the responsibility to take action where standards are not being met, or where the care, safety, security and rights of residents might be compromised;

"Affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, homelike environment and supports high quality of life for all residents of long-term care homes through a strong, viable and appropriately funded LTC homes sector;

"Recognize that long-term care services must respect diversity in communities;

"Respect the requirements of the French Language Services Act in serving Ontario's francophone community."

**The Chair:** This motion is out of order and can proceed only with unanimous consent. Do you wish to ask for—

**Mrs. Witmer:** Sure, I'll ask for unanimous consent.

**The Chair:** Do we have unanimous consent?

**Ms. Smith:** Wow, I wish it was 357.1 instead of 361. Sure, we can have unanimous consent.

**The Chair:** We have unanimous consent.

**Mrs. Witmer:** I think the attempt here is to ensure that the preamble reflects the need for the government to appropriately fund long-term-care homes in order that they can meet the requirements of meeting the assessed needs of residents. I think it also speaks to the need for some consistency and fairness in compliance, inspection and enforcement systems. Again, it does recognize that there is a need for a strong, viable and appropriately funded long-term-care homes sector. I think the issue of funding really is one that is very important. If we're going to meet the assessed needs of the residents, the funding simply needs to be there.

**The Chair:** Any other discussion?

**Ms. Smith:** We don't agree with the recommendations made by Mrs. Witmer in her changes to the preamble. We feel they're better addressed by motion 361. I would just note that we do include the notion of care in our amendment. We also include the notion of mutual respect, which we discussed many times as we were looking at the bill of rights in other sections of the legislation. We also obviously do not agree with her notion that the concept of funding should be included in the preamble. We also note the absence of her support for the not-for-profit sector, which we will be including in our version of the preamble. For those reasons, we feel that motion 361 is more appropriate and we'll not be support-



ing motion 358, but we're delighted to hear one last time Mrs. Witmer's speech on funding etc.

**Mrs. Witmer:** I'm going to now move away from funding, because the purpose of the preamble here, as it always is—it's a framework of the fundamental beliefs and principles on which you're building your legislation. It also is a guide to what it is you would hope that the legislation would do, and I think that the government's preamble has some gaps.

If you take a look at what we have today, the government's stated principles that they've used in two other key pieces of legislation are being ignored in Bill 140. If you take a look at the Commitment to the Future of Medicare Act and the Local Health System Integration Act, they include the principle of a common vision of shared responsibility, which is not currently here. They have ignored recognition of access to community-based health care, which includes long-term-care homes as a cornerstone of an effective health care system, and they have ignored the belief in public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest.

Again, I will go back to what I've said: I do believe it's impossible to effectively and efficiently deliver high-quality services without being appropriately funded.

**Ms. Martel:** I really like Mrs. Witmer's reference to appropriately funded long-term-care homes, which is why I raised the matter of funding at many points during the review of the bill in my amendments. I wish the government would incorporate that into their preamble, given that the vote on this is going to be very clear.

**The Chair:** Any other debate? Should I call the vote? I'll call the vote. Those in favour of this motion? Opposed? The motion is lost.

Motion 359.

**Ms. Martel:** Chair, I wanted to make sure that—wait a minute. I want to see the government's motion.

**Ms. Smith:** It's the last section, Shelley.

**Ms. Martel:** Was it in another section of the bill?

**Ms. Smith:** It's the last section of the new one that you just got.

**Ms. Martel:** What I've got in motion 361 is, "Are committed to the promotion of the delivery of long-term care home services by not-for-profit organizations," but there's no reference to the Canada Health Act. Did that come before in a previous amendment?

**Ms. Smith:** No, that's never been there.

**Ms. Martel:** You know what, then, Chair? I'm going to move this.

I move that the preamble to the bill be amended by adding the following paragraph at the end:

"Commit themselves to upholding the principles and conditions of the Canada Health Act, and support not-for-profit provision of long-term care."

I ask for unanimous consent.

**The Chair:** I have to rule it out of order because it applies to the preamble. It would be necessary for you to request unanimous consent.

**Ms. Martel:** I request unanimous consent.

**The Chair:** There's a request for unanimous consent.

**Ms. Smith:** No good deed goes unpunished. She has unanimous consent.

**The Chair:** I'll take that lengthy answer as a "yes." We have unanimous consent.

**Ms. Martel:** If I might, Chair, there are two principles here that I would like to see incorporated in the preamble. One is the support for not-for-profit provision of long-term care. The government does reference that in their motion and I want it to be included, which is why I referenced it in mine. Secondly, I think it's important as well that we include a reference to the Canada Health Act, in particular, "Commit themselves to upholding the principles and conditions of the Canada Health Act...." If I recall, that was probably part of the preamble of Bill 8, and I think it was part of the preamble of Bill 36. It was also strongly recommended by the Registered Nurses Association of Ontario. So I think this particular provision should be added so that it recognizes both a support for not-for-profit provision of long-term care and a commitment to uphold the principles and conditions of the Canada Health Act.

**The Chair:** I'll call the vote. Those in favour of the motion? Those opposed? The motion is lost.

NDP motion 360.

**Ms. Martel:** Chair, I'm going to withdraw this because the commitment to continuous quality improvement made its way into some amendments in the bill earlier on.

**The Chair:** Okay. That brings us to government motion 361, which was distributed separately.

**Ms. Smith:** I move that,

1. the fourth paragraph of the preamble to the bill be struck out and the following substituted:

"Strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the needs of the resident and the safety needs of all residents;"

2. the eighth paragraph of the preamble to the bill be struck out and the following substituted:

"Recognize the responsibility to take action where standards or requirements under this act are not being met, or where the care, safety, security and rights of residents might be compromised;"

3. the preamble to the bill be amended by adding the following paragraphs at the end:

"Recognize the importance of fostering the delivery of care and services to residents in an environment that supports continuous quality improvement;

"Are committed to the promotion of the delivery of long-term carehome services by not-for-profit organizations."

**The Chair:** Thank you. This motion is out of order.

**Ms. Smith:** I seek unanimous consent to deal with this motion.

**The Chair:** Do we have unanimous consent? Agreed. Yes, we do.

**Ms. Smith:** We've heard a lot of discussion about the upcoming amendments to the preamble, so here they finally are. We've tried to address the issue of group rights versus individual rights through the inclusion of "mutual respect." We were asked to try to include and address the issue around safety needs, and we have done so through the inclusion of "meet the needs of the resident and the safety needs of all residents...." We heard from our providers that they wanted to be included in the list of people who strongly support collaboration and mutual respect, and we've included them. We are including the notion of continuous quality improvement, as was requested by the OMA and others. As well, we are including our commitment to the promotion of the delivery

of long-term-care-home services by not-for-profit organizations.

**The Chair:** Any other debate? We'll call the vote. Those in favour? Opposed? The motion is carried.

Shall the preamble, as amended, carry? Carried.

Shall the title of the bill carry? It is carried.

Shall Bill 140, as amended, carry?

Lastly, shall I report the bill, as amended, to the House? It is carried.

That concludes the bill. Thank you very much. I have truly appreciated the professional approach taken by everyone on this very serious bill.

**Mrs. Witmer:** Thank you very much, Mr. Chair. You did an excellent job.

**The Chair:** I appreciate that. We are adjourned.

*The committee adjourned at 1543.*





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## Legislative Assembly of Ontario

Second Session, 38<sup>th</sup> Parliament

## Assemblée législative de l'Ontario

Deuxième session, 38<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 23 April 2007

# Journal des débats (Hansard)

Lundi 23 avril 2007

## Standing committee on social policy

Health System  
Improvements Act, 2007

## Comité permanent de la politique sociale

Loi de 2007 sur l'amélioration  
du système de santé

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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Monday 23 April 2007

Lundi 23 avril 2007

*The committee met at 1545 in committee room 1.*

## SUBCOMMITTEE REPORT

**The Chair (Mr. Ernie Parsons):** Petitions have ended, orders of the day have started, and I will call the meeting of the standing committee on social policy to order. We are meeting to receive input on Bill 171.

The first order of business is the report of the subcommittee on committee business. Mr. Mauro.

**Mr. Bill Mauro (Thunder Bay–Atikokan):** Your subcommittee met on Tuesday, April 10, 2007, to consider the method of proceeding on Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts, and recommends the following:

(1) That the committee meet in Toronto on April 23 and 24, 2007, for the purpose of holding public hearings.

(2) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on the Ont.Parl channel, the Legislative Assembly website and in the Ontario edition of Canada NewsWire.

(3) That interested parties who wish to be considered to make an oral presentation contact the committee clerk by 5 p.m. on Friday, April 13, 2007.

(4) That, in the event all witnesses cannot be scheduled, the committee clerk provide the members of the subcommittee with a list of requests to appear by 6 p.m. on Friday, April 13, 2007.

(5) That the members of the subcommittee prioritize and return the list of requests to appear by 5 p.m. on Monday, April 16, 2007.

(6) That groups and individuals be offered 10 minutes for their presentation. This time is to include questions from the committee.

(7) That the requested background material be prepared by the research officer by Monday, April 23, 2007.

(8) That the deadline for written submissions be 5 p.m. on Tuesday, April 24, 2007.

(9) That a summary of presentations be prepared by the research officer by Monday, April 30, 2007.

(10) That for administrative purposes, proposed amendments be filed with the committee clerk by 12 noon on Friday, May 4, 2007.

(11) That the committee meet for the purpose of clause-by-clause consideration on Monday, May 7, 2007.

(12) That the committee clerk, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

I move that the report be adopted.

**The Chair:** Thank you. Discussion?

**Mrs. Elizabeth Witmer (Kitchener–Waterloo):** I have a question. Number 11 says, "That the committee meet for the purpose of clause-by-clause consideration on Monday, May 7, 2007." I'd just to know, in the event of a lot of amendments, which is quite possible, given the feedback we're receiving, are we sitting beyond 6 o'clock that evening?

**The Chair:** If I could respond to that, it is required that the committee stop at 6 o'clock. However, the committee is authorized to meet Mondays and Tuesdays, so the committee could meet the following day, May 8, if necessary, which is a Tuesday.

**Mrs. Witmer:** Right. Thank you very much.

**Ms. Shelley Martel (Nickel Belt):** Very briefly with respect to the motion before us, I want to say that I am opposed to it, and I was opposed to it at the meeting of the subcommittee, for this reason: At the time that the subcommittee met, we already knew that there were 55 applications that had come into the clerk's office for people who wanted to appear, either people or organizations or a combination of both. That was before the committee had even advertised that we were going to meet and the days that we were going to meet. We have received some 118 applications, all told, and we are only able to hear from 30 presenters over the course of the next two days, so 88 groups and individuals are not going to be able to be heard. I expressed concern at the subcommittee meeting that we should hear from more people, and we certainly had the days to do it. It's clear that it is a very complex bill, with some 17 schedules—lots of interest. There are people in an overflow room right now. I think we made a serious mistake in not agreeing to hold two more days of public hearings so more people could be heard. So I'll be voting against this report.

**The Chair:** If there's no additional discussion, those in favour of the motion?

**Ms. Martel:** Recorded vote.

**Ayes**

Fonseca, Kular, Mauro, Ramal.

**Nays**

Martel, O'Toole, Witmer.

**The Chair:** The motion is carried.

HEALTH SYSTEM  
IMPROVEMENTS ACT, 2007  
LOI DE 2007 SUR L'AMÉLIORATION  
DU SYSTÈME DE SANTÉ

Consideration of Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts / Projet de loi 171, Loi visant à améliorer les systèmes de santé en modifiant ou en abrogeant divers textes de loi et en édictant certaines lois.

**The Chair:** That moves us now to the first presentation. I would ask whoever is making the presentation if, prior to speaking, you would identify yourselves for Hansard. It's necessary that you state your name. There are 10 minutes allocated for presentation. Any of the time you do not use will be divided equally among the parties for questions.

1550

ONTARIO NURSES' ASSOCIATION

**The Chair:** I would call first for the Ontario Nurses' Association.

**Ms. Vicki McKenna:** Good afternoon. My name is Vicki McKenna. I'm a registered nurse, and I'm the first vice-president of the Ontario Nurses' Association, ONA. Joining me today, on my far left, is Joan Boudreau. Joan is from our legal expense assistance team plan. Next to her is Lawrence Walter, our government relations officer. On my right is Kate Hughes, our legal counsel.

I'm speaking on behalf of over 53,000 front-line registered nurses and allied health professionals who deliver care in hospitals, long-term-care facilities, public health, community agencies, and other settings right across Ontario.

ONA is pleased to have this opportunity to provide the standing committee our concerns with Bill 171 from the perspective of front-line nursing. While we don't have time to review all of our concerns, we have provided the standing committee with our full submission.

I want to begin with our concerns regarding some of the proposed changes to the Regulated Health Professions Act and the Health Professions Procedural Code contained in schedule M. Specifically, ONA has grave concerns with respect to personal health information of our members to be placed on the public register and the college website, including a synopsis of the decision in every incapacity proceeding and the terms and conditions imposed on a member's certificate.

The grounds for a finding in an incapacity proceeding is typically a statement of the health condition that has caused this incapacity. The terms and conditions imposed in an incapacity case contain extensive references to a member's medical condition, diagnosis, treatment and other private personal health information. We have included two cases with our submission to assist the standing committee. Provisions that require publication of such information will have a disproportionate and discriminatory impact on members with disabilities, which in our view contravenes the fundamental rights to equality under both the Human Rights Code and the Canadian Charter of Rights and Freedoms. We understand that the government is trying to achieve greater transparency regarding college decision-making in order to enhance public protection. However, personal health information is highly sensitive and private and should not be placed on a public register or posted for all to see on a website.

ONA also has serious concerns with respect to mandatory reporting in all situations where a facility operator has reasonable grounds to believe that a member who practises at the facility may be incompetent or incapacitated. We believe the mandatory reporting obligation should be amended to apply only to situations where the public is at risk.

Often members deal with incompetence and incapacity concerns with their employers in a responsible fashion by acknowledging an underlying disability, withdrawing from practice and undergoing appropriate treatment. A member returns to work upon obtaining appropriate medical clearance. Many of these cases are not reported to the college because there is no risk to the public. If employers are mandated to report these cases to the college in the future, it will likely result in an unnecessary delay in members returning to work, since some employers will likely wait until the outcome of a college case before allowing a member to return. It may also negatively impact attempts to have members disclose their health condition and seek appropriate treatment. A report to the college will also place an unnecessary stressor on disabled members who are acting responsibly, when the focus should be on treatment and health.

ONA also has serious concerns with respect to the proposed legislative changes that will, in the future, allow the ICR committee, if it decides to refer a matter, to make an interim order to suspend or impose terms on a member's certificate of registration without notice to the member. This authority is unprecedented and a serious breach of the fundamental principles of natural justice and procedural fairness. There is no demonstrated need for such a radical departure from due process, as we are unaware of any cases where a member has harmed a patient while making a submission regarding a potential interim order.

In addition, ONA has serious concerns with respect to the requirement that the ICR committee, in deliberating about a complaint or report, consider all available prior decisions regarding a member. Again, it's a serious breach of the fundamental principles of natural justice



and procedural fairness. It's also extremely prejudicial to members, since it may lead to the disposition of a current matter, not on its own merits, but because of a previous matter.

Turning now to schedules F and K, we want to remind the standing committee that these proposed changes flow from Justice Archie Campbell's thorough and insightful report into the SARS outbreak. We find that schedule F ignores Justice Campbell's key recommendation that the precautionary principles are to be expressly adopted in the Health Protection and Promotion Act and all relevant health statutes. Accordingly, we also recommend codifying the precautionary principle in the Public Hospitals Act through schedule I.

In addition, Justice Campbell strongly recommended that the Ontario Health Protection and Promotion Agency have a well-resourced, integrated section that focuses on worker safety research and investigation and on integrating worker safety and infection control. Schedule K clearly fails to do so.

The functions of the corporation listed in section 6 make no mention of worker safety research.

The definition of "minister" in section 2 makes no mention of the Minister of Labour, the crown minister who is responsible for occupational health and safety.

Section 14 provides that the Chief Medical Officer of Health has automatic membership on the strategic planning standing committee, but no counterpart in the Ministry of Labour has similar standing.

Sections 22 and 23 provide that the board must issue reports to the Minister of Health and Long-Term Care and the Chief Medical Officer of Health, but is not required to issue reports to the Minister of Labour or other counterpart in the Ministry of Labour.

No occupational health and safety experts, Ministry of Labour specialists or labour representatives were given an opportunity to provide input as to the purpose, structure and functioning of the proposed new agency.

As a result, ONA is recommending that implementation of schedule K be delayed until a committee, comprised of the foregoing experts, is consulted and schedule K is redrafted accordingly.

Finally, ONA recommends that section 9 in the legislation be amended to expressly require labour representation on the agency board.

The nurses of Ontario insist that the lessons of SARS not be forgotten. The precautionary principle must be adopted, as Justice Archie Campbell recommended, and worker health and safety included as a fundamental component of this new agency.

We sincerely request that our submission be given serious consideration by the standing committee, and we thank you very much for your time.

**The Chair:** Thank you. We have one minute for questions.

**Mrs. Witmer:** Thank you very much, Vicki, and all of the nurses who are here.

One question I have for you: Obviously, you've been in preliminary discussions with the Ministry of Health on

some of these concerns. As a result of that, is there any indication that amendments are going to be made to certain sections that you've expressed concern about?

**Ms. McKenna:** Not that I am aware of, no.

**Mrs. Witmer:** Is there anything in here that would be different from the recommendations of the initial report, where directions were not followed per the report?

**Ms. McKenna:** Which report? I'm sorry.

**Mrs. Witmer:** That was put out by the RHPA. Is there anything contradictory here, or is this all that has come from the ministry?

**Ms. McKenna:** No.

**Mrs. Witmer:** There's nothing here? Barbara Sullivan had a report.

**Ms. McKenna:** No.

**The Chair:** Ms. Martel, there is about 20 seconds if you have a question.

**Ms. Martel:** Thank you for being here. Very quickly, in terms of putting the precautionary principle into schedule K, do you want it in the preamble, and are there other places where it could be included?

**Mr. Lawrence Walter:** Yes, it could be included in the preamble or it could be included in a separate clause. In the Campbell report there wasn't any specific language on where that precautionary principle should be. It should be included in any health statute, though, so we want it included also in the Public Hospitals Act, in the Health Protection and Promotion Act and in any other health statutes that are relevant. There are no changes—

**The Chair:** We're out of time; I'm sorry.

I will credit you one question for some later date.

1600

#### ONTARIO SOCIAL WORK DOCTORS' COLLOQUIUM, USE OF TITLE TASK FORCE

**The Chair:** I would ask next—I'm an engineer by training, so some of these words I may mispronounce, and I apologize—the Ontario Social Work Doctors' Colloquium, Use of Title Task Force. If you would state your name for Hansard, you have 10 minutes.

**Dr. Frank Turner:** My name is Dr. Frank Turner. My two colleagues with me are Dr. Nancy Riedel Bowers from Kitchener and Dr. Alex Polgar from Hamilton.

Mr. Parsons, members of the committee, I'd like to begin by thanking you on behalf of the Ontario Social Work Doctors' Colloquium for this opportunity to present in person our position concerning the use of the title "doctor."

Some time ago, we prepared and widely disseminated an extensively researched position paper that outlines a number of factually supported reasons why the Ontario government should amend a specific clause in the RHPA, a clause that prohibits social workers with university-granted doctorates from using their title when providing or offering to provide health services. I will leave copies of this document with you today and therefore will not summarize its content. Instead, I want to use this time to

convey some additional information; specifically what we have concluded based on our experience.

We are of the firm belief that the Ontario government's position regarding the use of the title "doctor" simply represents an absence of political will to rectify something that should never have happened in the first place. When the act was written and passed, there were no credible empirical bases for including in it the restriction clause pertaining to the use of the title "doctor." In spite of our concerted, indeed exhaustive, efforts, we have not been able to discover to date any credible evidence that would justify the restriction and thereby justify not amending the act now.

Therefore, in our view, the Ontario government's position on this matter appears prejudicial and discriminatory, violating the charter-guaranteed rights of social workers with university-granted doctorates. Our position, among other reasons, is based on the following:

The Health Professions Regulatory Advisory Council, after extensive analysis, which included broad consultations, in its New Directions report has recommended that the restriction on the use of the title "doctor" be amended, albeit without singling out any one discipline. In section 34, points 1, 2, 3, and 4, it is clearly spelled out how the amendment should be made. This recommendation has been ignored in the omnibus Bill 171 for, to us, no apparent reason. The Ontario government has not provided to us, or anyone else who has advocated on our behalf, any credible evidence for not making the recommended amendment.

Since we wrote and disseminated our position paper, we have also met with and discussed our issue with individuals, groups and a number of elected representatives. Without exception, all have been completely supportive. Many have conveyed their support in writing to the Minister of Health and Long-Term Care.

Anticipating a possible 11th-hour reason for not striking down the RHPA restriction concerning the use of the title, we have obtained a legal opinion. Our counsel, a recognized expert on regulatory laws, tells us that there are no legal impediments to modifying the RHPA as we have requested and as it has been recommended in the New Directions report. However, inadvertently, the intent of our request and the intent of the Health Professions Regulatory Advisory Council could be subverted. He has advised us therefore that, as in the Personal Health Information Protection Act—statutes that are intended also to apply to our profession—separate provisions be crafted referring specifically to social workers. This recommendation is consistent with the submissions made by both our college and association in response to the New Directions report.

Alternatively, the simplest solution would be to strike down and remove completely the prohibition in its entirety, leaving the issue of the use of the title "doctor" to be dealt with by existing general provisions dealing with false representations or misleading of clients.

No one we have spoken to opposes our request for the amendment, nor that which is recommended by the New

Directions report. Our colleagues in other disciplines acknowledged that the doctorate is the highest academic degree one can earn, that the degree represents a significant contribution to the discipline in which it was granted, and that the process for earning a doctoral degree conforms to a tradition that is 1,000 or more years old entrusted to the universities.

Now more than ever, much of the research conducted for a doctoral degree is directly applicable to practice. Currently, a researcher who does research can legitimately use the title, but if he turns clinician, he cannot use the earned title of doctor in his practice, although it was duly conferred by an accredited university.

While not explicitly addressed in our position document, the sacrifice, effort and commitment required to earn a doctorate requires reflection. Everyone who embarks on this arduous journey does so in good faith, seeking to advance their competence and to make a contribution to their field of study. On average, it takes approximately seven years after having earned a master's degree to complete a doctoral program. When the degree is conferred, it is done without conditions, restrictions or disclaimers.

It is therefore an absolute travesty that Ontario is the only place on earth where there is a restriction imposed on the use of the title "doctor." Nowhere else does this exist. It is an even greater travesty that the only rationale—public protection—has never had, and continues not to have, any empirical basis; none whatsoever.

On the contrary, instead of protecting the public, the RHPA-imposed restriction accomplishes the opposite. Specifically, the restriction is paternalistically derogatory to the public, which can and does seek information and uses it appropriately. Most importantly, in a climate of exponentially growing needs, the RHPA restriction limits the public's ability to make informed decisions about whose assistance they should seek and what quality of resources are available in Ontario.

I would like to conclude by reiterating that we believe the Ontario government's refusal, as reflected in the draft bill, to make the amendment that we requested and that was recommended in the New Directions report by the Health Professions Regulatory Advisory Council, is based on an unknown reason but clearly one that is simply conjecture. It is therefore markedly prejudicial to our group and the profession of social work. While perhaps well intentioned, this restriction is also inadvertently an impediment to those who are served by our profession.

We thank you again for the opportunity to speak to this issue.

**The Chair:** Twenty seconds per party, starting with the Liberals.

**Mr. Peter Fonseca (Mississauga East):** I'd like to thank the Social Work Doctors' Colloquium for its fine presentation, and all the social workers of Ontario for the fine work they do in providing social services as well as the delivery of psychotherapy. When it comes to schedule M—



**The Chair:** Thank you. Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Dr. Turner, for your presentation. I hope that when we come to the time for amendments, the government will recognize the need to lift this restriction on the use of the title “doctor” and that we are at the same place as everybody else—

**The Chair:** Thank you. Ms. Martel.

1610

**Ms. Martel:** Thank you for being here. Since social workers aren’t regulated under the RHPA, what’s the amendment you have to make under the RHPA to do what you want to do?

**Dr. Alex Polgar:** Strike it down completely, as was recommended to us, or provide a clause in the RHPA that specifically outlines that social work would be exempt from that.

**The Chair:** Thank you. We’re out of time.

#### ONTARIO HOMEOPATHIC ASSOCIATION

**The Chair:** The next group is the Ontario Homeopathic Association. While they’re coming forward, I’m going to suggest to the committee that where we have just a few minutes left, perhaps we’ll have just one party take the time.

**Mrs. Witmer:** That’s a good idea.

**The Chair:** I apologize for that. I started down a road I couldn’t get off of once I started.

I would also remind those who have cellphones—if you would turn them off. Perhaps you can put them on vibrate rather than ring. Heck, you might even enjoy a phone call.

Okay. The time is yours.

**Ms. Maya de Szegheo-Lang:** I’m Maya de Szegheo-Lang. As president, I represent members of the Ontario Homeopathic Association, referred to as OHA. With me is Mirsada Vins, head of the homeopathic department of the Ontario College of Homeopathic Medicine, referred to as OCHM. We would also like to acknowledge Ranvir Sharda, president, and members of the Homeopathic Medical Council of Canada, HMCC, who are in support of this submission.

We wish to thank the Chair and committee members for the opportunity to comment today on the regulation of homeopathy in schedule P of Bill 171.

The Ontario Homeopathic Association is a non-profit, voluntary association of highly qualified homeopaths who must adhere to a code of ethics and must meet educational and practice criteria which include specified hours of general arts and science courses, medical science courses, homeopathic instruction and clinical internship in homeopathy.

**Ms. Mirsada Vins:** Through review and consultation, the OHA proposes the following: With respect to the establishment of the College of Naturopaths and Homeopaths of Ontario, the OHA submits that homeopaths and naturopaths ought to be regulated under separate colleges. We acknowledge that naturopaths receive some education in homeopathic principles. It is common

amongst regulated health professions for there to be some aspects of shared knowledge or practice. However, homeopathy is a distinct system of medicine with a core body of knowledge that is unique to the practice of homeopathy. A separate college would provide homeopaths with the opportunity to develop the appropriate regulatory scheme for homeopathy in Ontario.

We note that when the College of Midwives of Ontario was created, it had 67 members. In the ensuing 14 years, its membership has grown to approximately 400 members. The OHA estimates that there are currently approximately just over 500 highly qualified homeopaths in Ontario who would be eligible for membership as regulated health professionals. As well, both the OHA and the OCHM have seen an steady increase in the past 10 years in the number of persons wishing to obtain homeopathic education. This increase in interest in homeopathy has been mirrored by an increase in members of the public who wish to have access to alternative medicine. There are sufficient number of homeopaths in Ontario to warrant and support a college of homeopaths of Ontario.

We acknowledge that experience and regulation is of great assistance when developing policies, procedures and programs. We expect to consult with and draw on the expertise of the many established regulatory bodies in Ontario and include representatives from other colleges on our transitional council. In our view, such collaboration and consultation is a more beneficial approach than relying on a composite college system.

Therefore, we recommend that schedule P to Bill 171 be amended to provide for separate regulatory bodies for homeopaths and naturopaths by creating a college of homeopaths of Ontario and a college of naturopaths of Ontario.

With respect to the use of the title “doctor,” the OHA and OCHM, amongst other homeopathic groups, such as the HMCC, have worked to establish the minimum standards for theoretical and practical knowledge required to undertake the diagnosis of conditions, treat within the scope of practice and make inter-professional referrals in the best interests of patient care.

The OHA recognizes that some homeopaths in Ontario have advanced theoretical and clinical training above those minimum standards. For example, homeopaths in many jurisdictions are required to have a medical or osteopathic medicine degree in addition to post-graduate training in homeopathy. The qualifications of such homeopaths match or exceed the academic and clinical requirements for regulated health professionals in Ontario, such as chiropractors, dentists, optometrists or psychologists, who are currently entitled to use the protected title “doctor.”

The government of Ontario has already acknowledged that within a regulated health profession there are practitioners with a range of experience and training and that it is appropriate in the public interest to recognize advanced academic and clinical training with the use of the title “doctor.” For example, in the Traditional

Chinese Medicine Act, 2006, all members of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario are provided with the restricted title "traditional Chinese medicine practitioner" or "acupuncturist." However, the council can make regulations regulating or prohibiting the use of the title "doctor" and can prescribe a class of certificates of registration for members who use the title "doctor."

This scheme gives the minister the ability to ensure there is consistency across the regulated health professions with respect to the prerequisite education and clinical experience that would entitle a practitioner to use the title "doctor." It also provides the public with an assurance that regulated health practitioners who are authorized to use the title "doctor" have extensive academic and clinical expertise.

Therefore, we recommend and propose that schedule P to Bill 171 be amended to provide the Council of the College of Homeopaths with the authority to make regulations similar to the authority provided in the Traditional Chinese Medicine Act, 2006, regulating the use of the title "doctor" and prescribing a class of certificate of registration for homeopathic members who use the title "doctor."

**Ms. de Szegheo-Lang:** We also feel that some controlled acts belong within the scope of homeopathic practice.

Communicating a diagnosis: Diagnosis is a vital and fundamental aspect of the homeopathic system of medicine. A homeopathic diagnosis is based on a patient's physical, mental and emotional condition, objective and subjective symptomology, history, diagnostic test results and physical exam findings. A homeopathic diagnosis is necessary to prescribe the correct homeopathic remedy and to identify and discuss treatment and conditions, including those that require urgent emergency medical attention.

Administering, by injection or inhalation, a prescribed substance: Traditionally, homeopathic medicines were administered orally or, if indicated, by inhalation. However, scientific research being conducted in a number of medical centres in Europe has established that some homeopathic medicines are more effectively administered by injection, so it is standard homeopathic practice in some jurisdictions to administer some homeopathic medicines by injection. Permitting a homeopath to perform the controlled act of administering a prescribed homeopathic substance by injection in accordance with the appropriate regulations is in the public interest. This will allow the most effective homeopathic treatment under prescribed conditions that protect the public.

Prescribing, dispensing, selling or compounding a drug as defined in subsection 117(1) of the Drug and Pharmacies Regulation Act: Most homeopathic medicines used in the practice of homeopathy in Ontario are defined as "natural health products" pursuant to the natural health products regulations made under the Food and Drugs Act. This means that they are not considered to be drugs as defined in the Drug and Pharmacies

Regulation Act and homeopaths can prescribe, dispense, sell or compound them. However, there are some homeopathic medicines contained in the accepted homeopathic pharmacopoeias which are not defined as natural health products. Homeopaths in Ontario cannot legally use them in the practice of homeopathy because, absent being defined as "natural health products," they are defined as drugs. It is a controlled act to prescribe, sell or dispense a drug.

In order to ensure that homeopaths and their patients in Ontario can benefit from the full range of homeopathic medicines in the homeopathic pharmacopoeia, homeopaths require the authority to perform the controlled act of prescribing, dispensing, selling and compounding homeopathic medicines.

Therefore, we recommend that schedule P to Bill 171 be amended to include the following: In the course of engaging in the practice of homeopathy, a member is authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

(1) administering, by injection or inhalation, a prescribed homeopathic substance;

(2) communicating a homeopathic diagnosis that may be identified through an assessment that uses homeopathic techniques and includes assessing the individual's physical, mental and emotional conditions and symptoms, and is used to prescribe the appropriate homeopathic medicine or therapy;

(3) prescribing, dispensing, selling or compounding a homeopathic medicine which is defined as a drug in subsection 117(1) of the Drug and Pharmacies Regulation Act.

We note that the council would also require the authority to make regulations concerning the three controlled acts.

Thank you for your time.

**The Chair:** Thank you. There's enough time for one question. I'm making an arbitrary decision that it go to the government because they did not get in on the first rotation. Mr. Fonseca.

**Mr. Fonseca:** Thank you, Chair. You're so kind.

I'd like to thank the Ontario Homeopathic Association. I'd just like to tell you that the commitment from this government is to make sure that right now there is an equal representation on the college between naturopaths and homeopaths. We are also seriously looking at separating the college.

I want to ask you a question in regard to standards in terms of education standards for a doctor. What standards are there? Is there a standard exam that all homeopaths take? Can you tell me a little bit about that?

1620

**Ms. de Szegheo-Lang:** No. As far as the Ontario Homeopathic Association, most members will have a BA coming into homeopathic study and then do what is equivalent to about a five-year university tenure in homeopathy.

**Ms. Vins:** We're also working toward increasing the standards to match those that exist in other jurisdictions



in the world that require medical degrees, training in the health sciences and an extensive training in homeopathy and in the clinic as well.

**The Chair:** We're out of time. Thank you.

CANADIAN UNION OF  
PUBLIC EMPLOYEES,  
AMBULANCE COMMITTEE OF ONTARIO

**The Chair:** I would call forward now the Canadian Union of Public Employees, Ambulance Committee of Ontario. Again, if you would state your name for Hansard.

**Mr. Michael Dick:** Good afternoon. I'm Michael Dick. I'm the chair of CUPE Ambulance Committee of Ontario. Joining me is Mr. Joe Matasic, CUPE national rep, CUPE Canada ambulance coordinator. I want to thank you for giving us this opportunity to appear to voice our concerns and give a presentation on Bill 171.

Emergency medical services have undergone almost constant restructuring since the downloading of EMS to upper-tier municipalities at the turn of the century. Many changes ensued, starting with changes in employment, for most paramedics. On the positive side, though, CUPE, along with some concerned members of the community, campaigned for public delivery of emergency medical services, and we have been largely successful in achieving this goal. CUPE has become the largest union of EMS employees, representing approximately 3,600 paramedics in different locations around Ontario.

Even after the downloading, restructuring continued, with municipalities gradually taking over the direct operation of EMS, where it had been delivered by hospitals or the odd for-profit corporation. With the municipalities now operating most services directly, the pace for restructuring has slowed of late, with only one major change in employment relationship in the past year, so some stability has now been achieved. One positive outcome of these changes is that paramedicine as a career has matured. While in the past many would only pass through the profession, more now see work in paramedicine as a full working-life career. With these changes, employers now also expect more commitment and more stability. This has real benefits for EMS. A less positive outcome of these changes has been the desire of some municipalities to narrow the scope of their responsibilities.

There has been an almost constant campaign to move transfers between health care facilities away from land ambulances. The result has been the establishment of a whole new industry: private, for-profit companies, often presenting themselves as ambulances or as paramedic services. These for-profit businesses are transporting patients. In the last few years, these vehicles have become a common sight on our roads. They are completely unregulated and have further fragmented our health care system, despite the government's stated aim of integrating health care. To date, however, they have been restricted to the transportation of the less ill patients. As

far as we can see, the main outcome is to replace unionized workers earning a reasonable income by workers who earn less. Currently, most of these transfer services are unorganized.

Now we see the second step in the campaign by the municipalities to escape some other EMS responsibilities: the creation of a new body to transfer seriously ill patients between facilities. This is the stated purpose of the legislated amendment. We understand that 20,000 such transfers occur now, which is a significant amount of work. We believe, however, that such transfers have the potential to become a much more important area of work for paramedics.

Aided by the establishment of LHINs, there is significant interest in regionalizing health care. So, for example, there is a lot of interest in creating trauma centres which would handle the bulk of the trauma cases. EMS, as first responders, may take the trauma patients to a local hospital, but after being stabilized, these patients may be transferred to trauma centres that are some distance away.

Currently, physicians and RNs attend the patients transferring between these facilities, but this is expensive, and in any case, physicians and RNs are not trained to provide these sorts of services. Highly trained critical care paramedics are supposed to take over, and such services are already provided in the city of Toronto by CUPE members who work for the city's EMS. Turning such work over to a new organization will, again, fragment the health care delivery and limit the career path for some paramedics working in land ambulance services.

Currently, there are two levels of work for paramedics: primary care, and advanced care. The advanced care has an additional skill set and training. There is a third, even more highly skilled level, known as critical care paramedics. Critical care paramedics are authorized to perform very specialized controlled medical acts, including the administration of specialized drugs and other intensive medical treatments that are often required during the transportation of critically ill patients. Examples of these acts include lab blood interpretation, monitoring arterial and central venous catheters, gastric intubation and suction, chest X-ray interpretation, management of chest tubes and chest drainage, and mechanical ventilation.

We are not convinced that putting all, or virtually all, of the critical care paramedics with one employer is a good practice in terms of human resources development. Extensive travel may be associated with the work, so we are uncertain this new organization will be a long-term career choice.

As well, the separation of critical care paramedic work from land ambulance services prevents land ambulance paramedics from aspiring to be critical care paramedics. Again, we are not certain this is best for the industry in the long run. The government characterizes this initiative as "integrating" critical care transport, but the initiative will separate critical care transport from the great bulk of ambulance services and ambulance workers.

Secondly, we do not know the exact division of labour between land ambulance and critical care inter-facility transfers. What exactly are the limits to the new role for Ornge? We presume the regulation will provide some clarity on this. We hope the government is open to discussing this important point before finalizing the regulation.

Finally, we understand that the legislation may be necessary to establish a new role for Ornge, the air ambulance organization of today, so that it can deal with the critical care, inter-facility transport. We do not understand, however, why the legislation has to be written in such an open-ended way; for example, it appears to envisage the creation of any number of new ambulance providers, including first-response providers.

Paramedics have been through extensive restructuring already. After all this change and struggle, we believe that more change in employment relationships at this point would be counterproductive. Moving in this direction or creating multiple ambulance employers in certain areas would, or could, create chaos in an industry that has already seen its share of change.

I'd like to thank you for the opportunity of presenting today.

**The Chair:** We have about 30 seconds, so I believe the next rotation—

**Mrs. Witmer:** I'll give it to Ms. Martel.

**The Chair:** Okay. Ms. Martel.

**Ms. Martel:** Thank you for being here today. You have some obvious concerns. What kinds of discussions have you had with the government about your input around what's currently in the bill, or the development of any regulations that flow under schedule A?

**Mr. Dick:** Very little, if any.

**Ms. Martel:** You've written to them, asked for meetings? What have you done?

**Mr. Dick:** We have just actually—we weren't really aware of this bill coming through, because it was put in with some other changes, so it just came to our attention in the last few weeks. We did contact emergency health services and had some discussion with them, but that's not the level where this needs to be discussed.

**Ms. Martel:** Were they reluctant to take it further?

**Mr. Dick:** We didn't really ask them to take it any further; it was just not something that was in their scope.

**The Chair:** We're out of time. Thank you.

**Mr. Dick:** Thanks.

1630

#### JOHN McEACHERN

**The Chair:** The next presenter is John McEachern.

Assuming that you're not both John McEachern, I would ask that you state your name for Hansard when you start to speak. You have 10 minutes.

**Mr. John McEachern:** If your son, your daughter or your loved one suffered a sudden cardiac arrest, would you want to do everything in your power to make sure that whoever saw them collapse had a defibrillator near-

by and did not hesitate even for one second to use it to save their life? Mr. Chairman, members of the Ontario Legislature, thank you for giving me this opportunity to speak to you about Bill 171. I am joined here by Rocco Rossi, CEO of the Heart and Stroke Foundation of Ontario.

I am speaking on behalf of my wife, Dorothy, and my son, Cole. I am John McEachern, the father of 11-year-old Chase McEachern, who passed away February 15, 2006, due to cardiac arrest. It is with my deepest sadness and great hope for the future that I stand before you today. It is on a deep personal note that I am here to support Bill 171 and especially the Chase McEachern Act (Heart Defibrillator Civil Liability), 2006.

Our son Chase was diagnosed with a heart condition known as atrial flutter. This condition caused his heart to beat very fast, sometimes for unknown reasons. Chase was diagnosed in October 2005. In November 2005, Chase witnessed a frightening scene during an NHL game. It was the sight of a Detroit Red Wings player, Jiri Fischer, collapsing from a similar condition that spurred Chase to write a letter to Don Cherry. Chase's letter to Don Cherry requested help to bring awareness to this heart condition and the need for more defibrillators, especially in arenas, because Chase loved to play the game of hockey.

Sadly for us all, Chase went into cardiac arrest February 9, 2006, during a gym class at school. A defibrillator did not arrive in time. Chase passed away on February 15, 2006, after six days on life support.

Soon after Chase's passing, Rocco Rossi, the CEO of the Heart and Stroke Foundation, called us, and together we created the Chase McEachern tribute fund. Donations to the Chase McEachern tribute fund are earmarked exclusively for the purchase of defibrillators, training in their use, and their placement in communities throughout Ontario.

Subsequently, with the ever-growing number of defibrillators being installed, it is easy to see the need for a civil liability act to promote their use. The Chase McEachern Act would ensure that users of defibrillators and the owners and occupiers of premises on which they are installed are protected from civil liability.

Chase had a dream to make defibrillators mandatory in arenas and schools everywhere. CPR and defibrillators can improve cardiac arrest survival up to 50% if delivered in the first few minutes. Let's make sure, by passing the Chase McEachern Act, that that help will be there and that no one else will hesitate to use a defibrillator. Because of Chase's dream, more lives can and will be saved by the use of defibrillators. The Chase McEachern Act will forever be a living legacy and a tribute to a special boy, our son, a boy who loved life and who shall help others live.

Just this past weekend, we got a letter from North Bay. Over the last week, there were two people in North Bay arenas who were saved by people stepping up and using defibrillators. It's just the start of what's going on.

**Mr. Rocco Rossi:** Thank you, John.



As John has mentioned, my name is Rocco Rossi. I'm the CEO of the Heart and Stroke Foundation of Ontario.

Sadly, Chase's case is not unique. Each and every year, some 7,000 Ontarians suffer cardiac arrest outside of hospital settings, and the current survival rate is less than 5%. With defibrillators and early CPR in the first few minutes we can increase that survival rate to 50% or above, so potentially 3,500 Ontarians a year could be saved instead of the current 300.

Sadly, each and every minute after you go into cardiac arrest, your chances of survival without treatment decrease by 7% to 10%, so there are 10 to 12 minutes to act. Literally, hesitation leads to death: hesitation on the part of donors to commit money to put more defibrillators into arenas, hesitation on the part of property managers to put these life-saving machines into their facilities, hesitation on the part of potential bystanders to do something in the case of cardiac arrest. So we applaud the government for including the provisions entitled the Chase McEachern Act within Bill 171. We strongly encourage the committee to support the bill, and particularly this element within the bill. We have many donors and expressions of interest from people who are simply holding back because of the lack of clarity on the liability issue. The current good-Samaritan legislation that's in place in Ontario, while good, is silent on the issue of defibrillators. This change would literally save lives, and I encourage you not to hesitate, because hesitation leads to unnecessary death.

Thank you again for allowing us to speak.

**The Chair:** We have about 50 seconds per party. I've lost track of where we were, so I'm going to go to the government caucus first.

**Mr. Fonseca:** Thank you, Mr. McEachern and Mr. Rossi, for your comments and your presentation. I know Chase's legacy will live on.

I would like to make a comment: One of our colleagues, Bruce Crozier, the MPP for Essex, brought forward a private member's bill. He wishes he could be here with us right now. He's actually in the Speaker's chair.

Allowing for the private sector and all to be able to have these defibrillators without the scare of being liable for their usage will, as you said, save many, many lives, and we can't act fast enough to get them out there. Thank you very much for presenting in front of us today.

**Mrs. Witmer:** Thank you very much for your presentation. Certainly we support this part of Bill 171 very strongly, and I appreciate your coming here today. I know that our colleague Joe Tascona, the member for Simcoe, is very supportive and certainly urged all of us to support it. At this point in time, as far as Bill 171 is concerned, obviously if the government wishes to pass that bill, that bill will pass, and we're hopeful that this section can become law.

**Ms. Martel:** Thank you, both of you, for being here. To Mr. McEachern in particular, thank you for coming and telling a personal story which was very difficult for you to do. I admire your courage in having made the decision to do that and to come to Toronto today. It was a

pleasure of mine, as NDP health critic, to speak on Bruce Crozier's bill, so it's a pleasure to meet you in person as well. We were supportive of the private member's bill and are certainly supportive of the schedule that has this change in it.

**The Chair:** Thank you for coming. Mr. McEachern, I want to particularly thank you for trying to make something good out of a tragedy. Chase's life was not without purpose. Thank you.

## ONTARIO PSYCHOLOGICAL ASSOCIATION

**The Chair:** Our next presentation is the Ontario Psychological Association.

**Dr. Jack Ferrari:** Mr. Chairman and committee members, thank you for giving us this opportunity to—

**The Chair:** I need you to state your name first for Hansard.

**Dr. Ferrari:** Okay. I was going to come to that. I'm Jack Ferrari, the president of the organization. With me on my left is Dr. Ruth Berman, the executive director, and on my right is Dr. Ian Nicholson, the chair of our RHPA task force.

Let me start by saying that we wholeheartedly endorse the current move to regulation of, and hence improvement in, the standards of provision of health services in the mental and emotional health area. RHPA was an important step forward in health regulatory legislation and has been very helpful in providing the parameters needed for the development of a full range of high-quality professional responses to the health needs of Ontarians.

The early emphasis of the RHPA, as it needed to be, was on physical health. We are very pleased with the current initiative, indicated by the creation of a new controlled act and by the broadening of the definition in the harm clause, to give mental and emotional health their proper place in the regulatory framework.

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We understand how difficult and contentious this legislation has been, and we would take the opportunity to offer all those involved our congratulations for their efforts and responsiveness in ensuring that the full range of professionally trained individuals, including our colleagues outside of the RHPA in the College of Social Work and Social Service Workers, have been included.

We do, however, have some significant concerns and would like to suggest what we hope are minor and acceptable modifications in the proposed legislation, in a spirit of collaboration and in the hopes of helping to ensure applicability and sustainability as the new regulations are implemented.

There are three interrelated matters we would like to draw the committee's attention to. We note that the part of the omnibus legislation to which we are responding, schedule Q, has as its aim the regulation of certain mental health activities which, if performed without requisite skill, could endanger the public—the group of activities

called psychotherapy. It also has the aim of regulating previously unregulated practitioners in a broad spectrum of mental health services. We believe that the distinction between these two legislative aims, the activity and the practitioner, may lead to a need for some amendments to the proposed legislation.

The legislation defines a new title of practitioner, the psychotherapist, and stipulates that only members of the new college will have access to this title. The reason cited is that the public will be able to identify the new practitioner and the regulatory body to which this practitioner belongs by this title. However, the term "psychotherapist" is in common public use, has a long history and belongs to many practitioners other than the newly regulated. In particular, we feel the title rightly applies to our members in one of their most important activities, and we feel the public would be deceived if there were a restriction of the title to a single group at the expense of the senior professions—psychology, psychiatry and social work, to which we would include some members of nursing and occupational therapy—all of whom can easily argue for the rightful use of the title.

There has been concern cited about the use of two titles, psychotherapist and psychologist, within the same college. We're unaware of any jurisdiction in which this has in fact caused a problem, and we would note that our members have learned in the years of being well regulated to be sure to present themselves and their services to the public in an accurate and complete manner.

Related to the difficulty in restriction of title is the proposed name of the college itself. The new college will do more than regulate a specific activity; it will regulate, for the first time, a heterogeneous group of professionals who work with mental health issues in a variety of ways and at a variety of levels, some practising with total autonomy, some within various supervisory and consultative structures. Yet the proposed name of the college is the College of Psychotherapists, with no indication in that title of the diversity of practitioners who will seek and gain entry. Moreover, this title may create a false impression among the public that the psychotherapeutic services of the other regulated professionals that have historically been identified as providing psychotherapy and who are also authorized to do so under this bill, such as our own, may not be at an equivalent standard or level of care.

Our own regulatory body, the College of Psychologists of Ontario, has proposed that the public will be better served, with less occasion for confusion, if the name is changed, to more reflect the proposed reality, to the College of Mental Health Therapists.

Finally, again following from the heterogeneity of the proposed college, we wish to state our concerns that the legislation, as currently proposed, seems to leave too many decisions regarding levels of membership and entry criteria to be determined by the transitional council of the new college without giving it the tools it may need.

Our own experience has taught us that, legally, a differentiation can be made between a title and a class,

and unless classes are defined in the enabling legislation, they cannot later be assumed simply because titles differ. Without a definition of classes of membership, class limitations, terms or conditions cannot be imposed. We would argue, however, that the new college is going to have to come to grips very early on with the need to impose class limitations because of the wide variety of backgrounds in individuals seeking entry to the college.

We would ask, then, that a clause be entered into the enabling legislation defining, at the very least, two classes, one of psychotherapists and the other of mental health therapists, who would not be expected to have access to the controlled act and, in some cases, would have a requirement for supervision in at least some of their professional activities.

We trust, as well, that our profession with its historical expertise will be invited to participate in the transitional council of the new college, and we would welcome the opportunity to do so.

**The Chair:** Thank you. There are about 35 seconds per caucus, starting with the official opposition.

**Mrs. Witmer:** Well, thank you very much. Have you had any discussions with the ministry regarding the change in name of the college to Mental Health Therapists?

**Dr. Ferrari:** Yes, we have.

**Mrs. Witmer:** And what was the response?

**Dr. Ruth Berman:** We did meet with members of the bureaucracy and with the people in the minister's office as well. There was an indication that they understood why we were concerned, but there has been no indication of whether the government intends to put forward any change.

As Dr. Ferrari indicated, one of the arguments in favour of the current name was that it would be clearer to the public which college a practitioner would belong to. But as you are aware, psychologists are psychotherapists, and the public has been aware that we're psychologists. We don't feel that that argument is warranted.

**The Chair:** We need to move on. Ms. Martel?

**Ms. Martel:** Thank you for being here today. I'm going to go to the last concern, where you say that a clause should be entered into the enabling legislation so that psychotherapists and other mental health therapists don't have access to the controlled act. Who would, then?

**Dr. Ferrari:** No, psychotherapists would always have access to the controlled act. What we are talking about is a clause similar to a clause in the Nursing Act that defines two classes. That enables the college to place terms, conditions or limitations on the class. There would be a class of mental health therapists who would not and should not have access to the controlled act.

**Ms. Martel:** Because of their level of education, etc.

**Dr. Ferrari:** Yes.

**The Chair:** We'll move next to the government caucus, then.

**Mr. Fonseca:** I'd like to thank you for your presentation. As we look to improve our health care system, we ask that it always be patient-centred and that various



groups work together, so that the colleges work together and always look to implement best practices. That's what we're asking for in this case. I thank you for your presentation.

**The Chair:** Thank you.

#### ONTARIO ASSOCIATION OF OPTOMETRISTS

**The Chair:** The next presenter is the Ontario Association of Optometrists. If you would state your names for Hansard.

**Dr. Joe Chan:** Good afternoon. My name is Joe Chan. These are my colleagues Dr. Christopher Nicol and Dr. Derek MacDonald, currently the president of the Ontario Association of Optometrists.

The Ontario Association of Optometrists, OAO, is pleased to have this opportunity to appear before the standing committee on social policy during the public hearings on Bill 171, the Health System Improvements Act, 2006. Founded in 1909, the OAO is the voluntary professional organization that represents almost 1,200 optometrists in Ontario. The association proudly serves the profession by performing a variety of government advocacy, membership education and public awareness initiatives.

Optometrists are professionally educated and clinically trained to provide community-based primary eye health and vision care services regulated under the Optometry Act, 1991, and the Regulated Health Professions Act, 1991. Optometrists provide comprehensive eye care for patients of all ages to optimize vision and prevent vision loss.

Comprehensive eye examinations contribute to the early detection and diagnosis of sight and potentially life-threatening diseases. Optometrists play a vital role in the assessment, diagnosis, treatment and continuing management of eye conditions for nearly three million residents in Ontario annually.

Optometrists are involved in preventive care, health maintenance, remediation and rehabilitation, and community health programs. Preventing blindness and preserving vision are priorities for Ontario's optometrists.

Our submission today is restricted to comments on schedule B, "Amendments Concerning Health Professions," section 17 on the Optometry Act, 1991, on pages 10 and 11. The proposed amendments to section 4 of the Optometry Act, 1991, will add the controlled act of prescribing drugs designated in regulations to the practice of optometry. The specified drugs will be subject to review by the minister and will be limited to those that can be used in the practice of optometry. The association would strongly recommend that this be accomplished through the specification of drug classes, with supporting practice guidelines to optimize care as new innovations in therapy rapidly evolve. Over 30 years of North American experience with the optometric use of therapeutic pharmaceuticals provides a ready reference for the specification of appropriate classes of topical and oral

medications by the council of the College of Optometrists of Ontario.

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Indeed, fully 96% of North Americans reside in state, provincial and territorial jurisdictions that presently permit optometrists to prescribe certain therapeutic pharmaceutical agents for ocular conditions. Optometrists in six Canadian provinces—Alberta, New Brunswick, Nova Scotia, Quebec, Saskatchewan and Newfoundland—and one territory, the Yukon, are permitted to prescribe pharmaceuticals for therapeutic purposes. Further, all 50 US states also extend therapeutic drug privileges to optometrists.

Ontario is one of the last jurisdictions in North America to authorize the prescribing of drugs by optometrists. The changes to the Optometry Act proposed in schedule B will provide the public with better access to a high level of eye care from qualified practitioners and will reduce health care costs by eliminating unnecessary referrals.

Graduates from Canadian optometric programs meet the qualifications for licensure in all jurisdictions in Canada and the United States. Optometrists are educated and clinically trained at the university level and have the necessary skills and knowledge to safely prescribe topical and oral medications for the treatment of eye disease. In fact, "Graduates come away with the skills to therapeutically manage eye conditions, including ocular surface diseases, eye and eyelid infections, ocular inflammation and pain, ocular allergies and glaucoma." To qualify for registration, graduates of optometric education programs, including the optometry program at the School of Optometry at the University of Waterloo, typically complete a minimum of seven years of university education.

We understand that this legislation is premised on the advice that Minister Smitherman requested and received from the Health Professions Regulatory Advisory Council, HPRAC, on the question of expanding the scope of practice of optometrists to include prescribing drugs. HPRAC undertook an independent, comprehensive and evidence-based review of that question. The process of review included literature and jurisdictional reviews, stakeholder consultations and an examination of the proposed pharmaceutical categories by an independent pharmacological expert.

The review determined the following:

—"The vast majority (75%) of optometrists in Ontario have the requisite knowledge, training and education to appropriately prescribe therapeutic pharmaceutical agents."

—"The public safety experience has been impressive in jurisdictions that have enacted legislation allowing optometrists to prescribe TPAs."

—"HPRAC's jurisdictional review of provinces and territories where optometrists are authorized to prescribe TPAs failed to find any evidence of patient complaints or safety issues."

—"Enhanced access for patients to a qualified health care provider of their choice generally improves the system's accountability to the public."

—"Broadening the scope of practice for optometrists by permitting limited use of TPAs will provide more access to care for Ontarians, make Ontario a more attractive location for optometrists to practice, and help address some of the physician-supply problems in the province."

HPRAC recognized that some practitioners might not currently possess the required training to prescribe therapeutic pharmaceutical agents. Further educational opportunities will be provided to the profession, and the College of Optometrists of Ontario will continue to establish and enforce practice standards and guidelines to ensure practitioner accountability. The association also believes it is critical that the College of Optometrists develop guidelines on after-hours and collaborative patient care, as we look forward to continuing to work with our colleagues in pharmacy and medicine. OAO is confident that the College of Optometrists can fulfill these mandates.

In Ontario there is one optometrist for every 9,139 residents, compared to one ophthalmologist for every 30,000 residents. Optometrists are readily available to provide the essential eye care services required by the residents of Ontario. More than 1,400 optometrists are widely distributed across the province, serving over 220 communities.

Optometrists are located in the majority of communities that were designated by the Ontario Medical Association and the Ontario government as being underserved. Further, in many of these underserved communities, optometrists are the only source of specialized eye care.

Optometric care is timely, easily accessible, safe and cost-effective. Moreover, adding the controlled act of prescribing topical and oral drugs to the practice of optometry will allow optometrists a broader range of treatment options to better meet the eye care needs of the public throughout Ontario.

An increased scope of practice for optometrists will permit more efficient treatment, since patients will receive more complete care from a single qualified practitioner. There will be fewer referrals of optometric patients with eye disease to either a hospital or a physician for treatment.

Clearly, the addition of the controlled act of prescribing drugs to the scope of practice for optometrists will have significant benefits for the residents of Ontario. Accordingly, OAO respectfully requests that this committee approve the proposed amendments to section 4 of the Optometry Act.

Thank you for your time today and for the opportunity to present the views of OAO on Bill 171 to the committee. If you have any questions, I would be pleased to provide answers.

**The Chair:** I'm sorry; you've timed it to fit 10 minutes.

**Dr. Chan:** Oh, okay.

**The Chair:** I'm sorry. There is no time for questions, but thank you for being with us.

## ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

**The Chair:** The next presentation is the Royal College of Dental Surgeons of Ontario. Welcome. If you would state your name for Hansard.

**Mr. Irwin Fefergrad:** My name is Irwin Fefergrad. I'm the registrar of the Royal College of Dental Surgeons of Ontario. The royal college is the regulator for some 8,000 dentists and has been around since 1869. I myself am a lawyer and I'm certified as a specialist in civil litigation and health law. I tell you that not to impress you but perhaps to suggest I might come with a touch of a different perspective.

Our college supports the amendments to the RHPA and commends Barbara Sullivan and HPRAC for their thoroughness in consultation not only with the colleges but, as well, with the public members who have been appointed by government to sit on our council.

I thought what I would do is spend a few minutes and do some nuts and bolts for you on three or four areas that might be problematic. As you know, we deal with this legislation every day under the RHPA, and we do have concerns about some of the drafting or perhaps some of the intentions in the sections.

The first one I'd like to approach is section 38, which speaks to pre-hearings. Most colleges have pre-hearings. We do; we've had them for about 10 years. The act proposes that the chair appoint a panel from the discipline committee to sit as pre-hearing conference people. I can tell you that this will create havoc with quorums for a discipline hearing. I can tell you that it would create conflicts, and it's not necessary. I think it ought to be left to the chair to appoint perhaps a public member, in our case a dentist, who would be best qualified. It doesn't have to be a member of the discipline committee. It could be somebody who has already been on council. It could be somebody perhaps who has taken courses in this kind of activity.

So my first submission to you is to rely on the Statutory Powers Procedure Act. It sets out fairness. Don't handcuff the colleges by requiring a panel to come from where the quorum has got to be drafted and taken anyway for discipline.

Second, under the section 75 provisions, which are the investigative provisions, usually a registrar's investigation confirmed by the new ICR committee, the statute, as amended or as proposed, suggests that the investigation ought to take place at the place of practice. In today's environment, that's very limiting. For example, we have now health professional corporations, and the books and records may not be in the practice. They may be in an accountant's office. They may be in another office which might be the head office of the corporation, which may not be in the practice. It seems to me that in order to protect the public and allow the colleges to do their work, you might wish to consider allowing the investigation to take place wherever the records are held. Our bread and



butter in these investigations, of course, is access to books and records, especially when dealing with fraud or billing for unnecessary services, that kind of activity. If we don't have access to the place where the books and records are actually kept, we will be handicapped in doing the job that you entrust us with.

1700

My third nuts-and-bolts point for you is the ADR provisions: lots of good things in it. It speaks to confidentiality, which is important in any ADR proceeding; it speaks to consent of the parties—of course, absent consent, you're not likely going to get a very good resolution; and it speaks to some independent facilitator, all of which are very commendable. Frankly, for those of us who have had ADR experience, that's the hallmark of our own internal process.

The problem in the proposed legislation, however, is that it proposes that the investigation continue parallel to an ADR process. I can tell you, that won't work. What will happen is that it won't stop the adversarial mechanism that's in place, necessarily. When you have a complainant, in our case a dentist, it won't encourage facilitation. In fact, some wily folks may use the ADR process to try to gear up the college's machinery to gain some ends through the new ICR process. I would urge you therefore to provide for an interruption of the investigation process to allow for a fulsome exchange, for the mediation process to take place in a meaningful way with the parties through the proceedings, namely the complainant and the member, to try to resolve it themselves without having another time clock or another agenda.

My final nuts-and-bolts—I can't tell if this is really drafting or intention. In our college's submissions to HPRAC, we recommended that the complaints committee and the executive committee, now the ICR committee, have the ability to order courses. So if a member has a problem, say it comes out of complaints, the ICR committee identifies legitimately that there are some problems with the member's standards of practice, it would be very helpful for the committee to order that the member take a course. Today we get around it by encouraging the member to sign an agreement, and most of the time the member does. But under the proposed legislation, it appears that it says you need to look at the quality assurance provision. So if you look at subsection 26(2), it says that the ICR committee has similar powers to the quality assurance committee in section 80.2. Section 80.2 says that in order to determine those powers, you need to look at section 82. Section 82 provides for an assessment before there can be some sort of resolution on courses.

It's far too cumbersome. I don't think that was the intention of HPRAC. I think HPRAC really intended to say, "Look, if your ICR committee determines that a member needs to get to a course quickly so that the public is protected, let's not waste time by going to another committee and have another assessment." I don't think that's really what is meant, although I think there is

some clumsiness in the drafting. I would say that if it's drafting clumsiness, let's fix it. If it's intention, then the intention is not going to protect the public. You're going to have the same bad practice or the same standard of practice that's not meeting standards continuing for far too long a period when the primary committee, the ICR committee, will have its finger on the pulse of the member's practice and be able to deal the appropriate courses.

Two very quick items, more philosophical, I suppose: One is the regulatory provisions. Generally speaking, it's very difficult for colleges to get regulations through. There is competing time, I suspect, at cabinet. It's not so easy, and as a result many of our regs don't get the attention as quickly as we'd perhaps like. It might be useful. I'm just a dumb lawyer, so I don't know how this works, but it might be useful if you would give consideration to the minister himself or herself perhaps being able to sign off on regs and give effect to it—just a suggestion.

Second, the public members are wonderful appointments. Part of the problem is that they come with very little education as to the college's processes. They do not understand how much time is committed until they actually get to work. They do not understand their responsibilities until they're given a lengthy orientation.

For us, we're handicapped when a public member's term expires if we're at the brink of our quorum. We've had a situation where we've been below our minimum number of public members, and consequently, it means that the complaints committee, the discipline committee and all the statutory committees of the college can't function. So I would suggest that you might consider, if somebody's term expires, simply having it extended until there's a replacement; or if the government of the day doesn't wish to do that, then to say that by virtue of falling below the minimum, the work of the rest of the statutory committees doesn't fall by the wayside, and there's an implied quorum.

I think that's all I really wished to say.

**The Chair:** We're out of time. Thank you very much.

#### ONTARIO ASSOCIATION OF NATUROPATHIC DOCTORS

**The Chair:** The next presentation is Sheryl Sasseville. I believe I'm pronouncing it—pardon me, I'm out one; the Ontario Association of Naturopathic Doctors. I'm just checking whether you folks are keeping track or not. I make mistakes intentionally once in a while—more as I get older.

**Ms. Ruth Anne Baron:** Good afternoon. I'm Ruth Anne Baron, naturopathic doctor and past chair of the Ontario Association of Naturopathic Doctors. Joining me is Alison Dantas, CEO of the Ontario Association of Naturopathic Doctors, which is the professional association representing Ontario's registered naturopathic doctors. Our purpose for appearing here today is to offer the committee our recommendations for improvements to Bill 171, most importantly to ensure that the Naturopathy

and Homeopathy Act will not reduce the scope of practice that naturopathic doctors currently provide to patients.

Let me start by stating that we welcome this legislation. By improving the regulation of Ontario's naturopathic doctors, this legislation shows a commitment to supporting Ontarians who choose complementary health care by making sure that they have better access to high-quality care.

Ontario now has over 800 naturopathic doctors, more than anywhere else in North America. We are currently regulated under the Drugless Practitioners Act and are highly trained primary care providers with an educational structure similar to that of medical doctors.

Naturopathic doctors practise a unique and comprehensive form of medicine which helps our patients to live healthier lives and has resulted in a growing demand for naturopathic medicine. Naturopathic doctors support and stimulate the body's ability to heal itself, focusing on prevention and the integration of standard medical diagnostics with a broad range of natural therapies. The primary goal of naturopathic treatment is to understand and address the cause of illness, rather than simply treating or suppressing symptoms.

The government committed to us at the outset of the legislative process that their goal was to ensure that we moved into the RHPA with our scope of practice intact, and we've been working closely with them to accomplish this. We would appreciate your support in making these needed changes which will preserve the current scope of practice and treatment options available to our patients.

Certainly we understand the challenges the government has faced in preserving our scope of practice and providing the necessary controlled acts in the move from the Drugless Practitioners Act into the Regulated Health Professions Act. For the most part, Bill 171 has been successful at implementing HPRAC's recommendations on how to accomplish this. I will focus on three critical issues that still need to be addressed.

The first is our scope of practice statement. The proposed statement is simply not an accurate description of our profession and does not fully describe the scope of practice that we currently have under the Drugless Practitioners Act. We are asking for the scope statement to specifically recognize that we perform diagnosis and treat diseases as well as disorders and dysfunctions. The scope statement also needs to specifically recognize the essential approach of naturopathic medicine to treat the whole person, and we have proposed wording in our written submission to accomplish this.

The second issue is the description of the controlled act of diagnosis. Bill 171 creates the concept of a naturopathic diagnosis, and we are concerned about the consequences of establishing this as a concept that appears to be different than a diagnosis made by a chiropractor, dentist or medical doctor. The change of removing the word "naturopathic" is important to us and to our patients, because the ability to have a shared understanding of diagnosis will make it easier to collaborate with other

primary care practitioners. Otherwise, we're just creating silos in the health care system, rather than the kinds of relationships that will benefit our patients.

1710

We're also seeking wording changes to more closely model our controlled act on the current description of communicating a diagnosis under the RHPA, such as specific reference to disease and symptoms. These changes are outlined in our written submission.

The last issue with regard to preserving our full scope of practice is ensuring that we can continue to access the natural substances that are integral to naturopathic medicine. This is essential for the treatments we provide to our patients. The problem is that more and more natural substances are being reclassified as prescription drugs by the federal government and thereby removed from the treatment options available to NDs for their patients. This reclassification is simply because it has been determined that these natural substances are not suitable for over-the-counter sale to the public. The issue then for naturopathic doctors is that unless the province provides us with access to a specific formulary of drugs, these natural substances will also no longer be available for use in naturopathic medicine.

This is why HPRAC recommended we should have the controlled act of prescribing. I can assure the committee that we have no interest in seeking access to pharmaceuticals. However, we need the controlled act to have a mechanism that will preserve our access when natural substances become reclassified by the federal government, as is continuing to happen.

Next, I want to bring your attention to our concerns about how Bill 171 proposes to change our title to "doctor of naturopathy," and the confusion this could create for the public. In short, "doctor of naturopathy" is not the title we use in Ontario. Across North America, this title is understood to be used only by poorly trained, unregulated practitioners. Changing the legislation to permit the continued use of our current title, "naturopathic doctor," will maintain the public's confidence that they are seeing a regulated health care provider.

Likewise, we'd appreciate the college to be named the College of Naturopathic Doctors, and where the legislation refers to "naturopathy," this should be changed to "naturopathic medicine." Getting the descriptions of our profession right is important to the profession, to our patients and to the general public.

The last topic I want to raise today is our concern about a joint college. Naturopathic medicine is a distinct system of primary care that addresses the root cause of illness and disease and promotes health and healing using natural therapies. Preserving and maintaining the tenets of naturopathic medicine is better done by having our own regulator made up of professional and public members.

I think it's clear that the two professions are at very different starting points. The transition for naturopathic doctors to be regulated under the RHPA is going to be quick, efficient and relatively straightforward. We have



been regulated under the Drugless Practitioners Act for over 80 years and we already have standards of practice, eligibility requirements and a united profession.

We are concerned also about who is going to pay for transition, given that homeopaths are not currently regulated. Naturopathic doctors are not willing or able to bear the financial burden of regulating another profession. Also, creating this joint college simply adds to the challenge the public has in differentiating between the two professions. I would urge you to let each of our professions maintain our distinct identities and approaches to medicine and move at our own pace by awarding us our own self-regulating college. If a joint college is still the preferred option of the government, naturopathic doctors will work with homeopaths as long as the concerns we've raised regarding financial burden and differing pace of evolving through transition are addressed.

We also have some specific comments on the transition council itself. Naturopathic doctors are committed to modernizing our standards of practice and incorporating the best practices of other regulated health professions as we move under the RHPA. That's why it's important to have a transition council that has broad professional member representation that is selected through a clear and transparent process. We strongly urge you not to make amendments which would limit this fresh start by adding provisions related to the transition council, unless it's limited to the transfer of assets from our current regulator.

We believe that our amendments will strengthen Bill 171 and allow Ontario's naturopathic doctors to be able to maintain the care that they're already able to provide under the Drugless Practitioners Act. As well, separate colleges will ensure that there's a clear and more effective transition for both of our professions. Our written submission includes more details on the need for these changes and the proposed wording necessary to implement them in Bill 171.

I want to thank all members of all parties for the support you've shown for naturopathic medicine over the years. Thank you.

**The Chair:** I'm afraid we're out of time. Thank you very much.

SHERYL SASSEVILLE

**The Chair:** The next presentation is Sheryl Sasseville. Welcome.

**Ms. Sheryl Sasseville:** Thank you.

Good afternoon. I'm Sheryl Sasseville. I'm owner of Onsite Dental Services in Sudbury.

Mr. Chair and members of the committee, thank you very much for the opportunity to speak to you today. I'm a registered dental hygienist who has been struggling to work in long-term and residential care homes for the last four years. I'm here today to represent myself and this population in Greater Sudbury of about 5,500 seniors.

The following have been my experiences that I have been struggling and celebrating for the last four years. It will serve to create an abstract of current situations at hand and hopefully answer any questions brought forth. The year 2007 is a happy year for me because the Legislature's decision on the passage of the amendments on the Dental Hygiene Act in schedule B of Bill 171 either reinforces or clearly states to me that the long road I have travelled will have been worthwhile and that the struggles I have been dealing with can finally stop.

Please allow me to state my business's mission statement, which I wholeheartedly believe in and follow with accuracy: "Onsite Dental Services strives to provide services to individuals who have difficulty obtaining dental treatments through conventional dental practice settings. We endeavour to help maintain optimal oral health with all citizens and our clients and encourage the highest quality with respect to current standards."

Many months of applying to conventional dental practices with seven years' experience proved to me that there are very few job openings in Sudbury for dental hygienists. Unable to find a job in a dental practice, in January 2002 I started a two-year study complete with surveys, statistical review and pro forma financial projections to see if an independent dental hygiene service would be beneficial and successful in long-term-care homes. There was no service of this kind and no previous attempts to start this type of service, at least of which I was aware. Not only did I find the service would be used but it was also very much appreciated, due primarily to residents' mobility barriers.

Knowing that I needed an order from a dentist, I brought forward my idea to a local dentist whom I worked for years ago. Not only was he excited, but he told me that my timing with this idea was impeccable because this was an issue the dentists were addressing at their last society meeting one week prior. They were not able to solve the issue of long-term-care homes, and he thought this was a wonderful solution.

Anxious to bring the idea forward to his peers, he told me he would contact me as soon as the meeting took place. He told me after that even though my idea would solve their dilemma, it was not only turned down but it turned into a very heated discussion with dentists upset about a dental hygienist working in this capacity. I offered to go to their next meeting to explain the findings in my survey and how much this service is needed. The dentist told me honestly that he thought it would be like throwing me to the wolves.

He believed along with me that this service was required, and started coming in with me to long-term care, examining patients and signing orders for the much-needed cleanings. Unfortunately, he moved away after about a year of working with me, leaving me to seek help from other local dentists.

After he moved away, I made many attempts to have some of the over 70 local dentists participate with me. Yearly mass mail-outs explaining my services and asking for help have gone out to every local dentist, with not one

response, either positive or negative. Several times, I have formally requested to meet with the local dental society to make a formal presentation on how necessary it is to provide onsite services to this population of Sudbury who cannot get out, and each time I was verbally denied the opportunity.

Acquiring participation from the local dentists has been a struggle from day one and continues to be a struggle, including being denied orders from residents' current dentists, to driving all over the city with charts to obtain an order. I have been verbally abused by dentists, had dentists demanding commission from my work and had one dentist who told one of my clients' power of attorney that what I am doing is illegal. I received one order from a dentist to proceed with the cleaning for one of his patients, but he then refused to sign the client's insurance claim form and subsequently sent me a letter citing that he would not participate in my "back door" efforts.

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For approximately one and a half years, two local dentists have been signing orders for me to provide services based on my completed charted assessment findings after I physically take each client's chart to their dental clinic. Before agreeing to this process, the dentists contacted their college to ask them if it is permitted. The RCDSO told them that due to the clients' circumstances, it would be allowed without concern of my level of education above and beyond what I have acquired through post-secondary education and ongoing courses. This went on for about a year.

In June 2006, the two dentists called me to a meeting, telling me that they would no longer sign orders for the clients unless they examined them first. Seeing that there were no dentists accompanying me to the long-term-care homes, they requested that all of my current and new patients visit their offices. I explained that residents in long-term care signed up for my service because they cannot or will not attend a traditional dental practice for a variety of reasons. Reasons varied from being too stressful on the resident, medication timing issues, wheelchair access, transportation issues, incontinence, family support attendance, money, forgetfulness and many more. "That's what the Handy Transit is for," was the dentists' response. "Book the Handy Transit, fill it with 15 or so seniors and bring them to our office for exams." I inquired, "What is Mrs. X with Alzheimer's and incontinence issues supposed to do for hours while the other 14 clients are being assessed, not to mention the confusion, missing meals and medications?" I contacted many patients to notify them to visit a dentist's office for an exam and was told in many cases that it was impossible to do so. They are upset because they are going to no longer have this service due to new barriers put in place by dentists.

With dentists no longer providing support, long-term-care residents will lose the service that I am offering and revert to emergency care only, with which this model would require transport every time to a dental clinic: no more preventive care, oral hygiene instruction or advo-

cating proper oral health, and therefore little, if any, improvement to overall health; no more proper screening for potential oral cancerous lesions and prompt early care; no opportunity to truly study dental issues in the aged and no furthering of the science; and a sudden and unnecessary ceasing of the excellent oral hygiene they maintained prior to entering long-term care.

I was assured in June 2006 that ongoing efforts from dentists were being made to try to get more dentists to accompany me for dental exams in long-term care. It is now April, 11 months later, and not one dentist has entered a long-term-care home. I have advised these homes and the clients' family members that at present I am not giving up, and have asked for their assistance in calling the dentists, politicians and other large organizations.

I read in an Ontario Dental Association magazine that provincially there are over 900 dentists working in long-term-care homes. Where are they? Precisely, the article states that over 900 dentists are on a list of having provided a service in a long-term-care facility. The article does not state how often service was provided. Therefore, in theory, a dentist visiting a sick relative and rendering some dental care four years ago is now on the list of practising within a long-term-care home. I can attest that in my city, dentists do not visit long-term-care homes due to the facilities' not having proper equipment such as a dental chair. Forget that, all the while, Mrs. M has an abscess that she has tolerated for some months. Because there is no dental chair and she cannot get out, the abscess will eventually cause a systemic infection that will cause her complications due to her already compromised health status and, further, the routine medications that she takes because of her advanced age now complicate her recovery. I have all of the equipment required to meet the standard of care, including a dental chair and a registered portable X-ray unit. I have been using this equipment without issues or errors for four years.

**The Chair:** You have one minute.

**Ms. Sasseville:** Two dentists have used my equipment for fillings.

I would like to finish now on my latest struggle. A month ago I was told by a dentist that there are now 25 local dentists who are signing up to help me in long-term-care homes. They also want to use Sudbury as a pilot project for long-term-care homes for the rest of the province. I have to ask myself why, in the last four years, I have struggled so hard for support, and now suddenly there are 25 dentists who want to help me. The only conclusion I can come to is this bill. The dentists want to take all of the systems I have developed and put into place to implement in other long-term-care homes throughout Ontario. If the dentists' concern is truly to care for the residents in these homes, they would have started helping me four years ago, when I began, not starting at full tilt when there is the possibility of this bill being passed.

At their last meeting, I was told by a dentist that one of these 25 dentists expressed concern that if this bill passes, I will open up a private dental hygiene—



**The Chair:** I'm sorry. We certainly will finish reading it prior to deliberations. We appreciate your being with us.

**Ms. Sasseville:** Okay. Thank you.

#### ESTHER ALLEN-FOGARTY

**The Chair:** The next presentation is Esther Allen-Fogarty.

**Ms. Esther Allen-Fogarty:** Good afternoon. My name is Esther Allen-Fogarty. I'm a nurse practitioner, RN(EC), BSCN, master's in nursing. I hold certificates in diabetes and an aeromedical certificate as well. I'm 14 years an RN and five years an RN(EC)/NP. The majority of my nursing career has been in northern Ontario rural areas. I'm presently a proud member of the Espanola star family health team. Yes: Espanola, on the map.

#### *Interjection.*

**Ms. Allen-Fogarty:** That's right. That's why I wear my Liberal red today.

**The Chair:** If they're bothering you, I'll take care of them.

**Ms. Allen-Fogarty:** I get extra time heckling with you guys.

I want to speak to you today re: the amendments to the Nursing Act, 1991 made in Bill 171. Specifically, section 14 of the Nursing Act is amended by adding the following subsection: "Individual drugs or categories." In subsection 1.1, "A regulation made under clause (1)(d) may designate individual drugs or categories of drugs." The addition is "categories of drugs."

As stated by the Honourable Mr. Smitherman on January 30, 2004, the goal of the Health System Improvement Act is to increase Ontario's access to services and regulated health care professionals. Amending the act to include categories is a step in the right direction to increase access to care, but I argue that the amendment is grossly insufficient in enhancing the services the NP can provide to patients. Why is the amendment insufficient? Because it doesn't remove the barrier of the list of drugs, now to be a category list. It doesn't allow flexibility to address the clinical nuances of individual cases. It doesn't eliminate the barrier of the lab and diagnostic imaging list.

Firstly, speaking to the barrier of the drug, now to be a category list, this list of drugs and categories does not keep pace with the most recent scientific research. For example, the vaccine Gardasil, which prevents cervical cancer, is now on the market and MDs can prescribe it. Yet the NP cannot prescribe Gardasil because it is not yet on the list.

Not having expedient access to new vaccines undermines my ability to meet the mandate of the scope of my practice, which is to prevent disease—College of Nurses of Ontario, 2004. It takes years to have the list amended through an act of Parliament. Proof in point: the 2005 proposed amendments to the drug list were just approved in March 2007—see the CNO website.

Secondly, it doesn't allow flexibility for the NP to address the clinical nuances of each case. NPs deliver essential primary health care services in multiple settings. It is not logical that a specific drug list or categories will ever be comprehensive enough to cover all the clinical nuances of each case.

In summary, the NP is quite competent and capable of ordering and adjusting medications. This is supported by a Carryer, Gardner, Dunn and Gardner article in 2007 that says that NPs are capable of synthesizing the appropriate multiple disciplinary guidelines and, combined with clinical judgment and experience, are capable of prescribing the appropriate pharmaceutical intervention based on the individual needs of the patient. Presently, we're limited by the drug and lab list barrier.

It doesn't get rid of the lab diagnostic imaging list; it's a specific list of what NPs can actually order. For example, we can order arm X-rays, leg X-rays and abdominal ultrasounds. But if the patient needs a shoulder X-ray or to be screened for prostate cancer or osteoporosis, they unnecessarily need to see another health care professional or they go to the ER or they go to a walk-in to have the test ordered as the NP is not able to order them the specific lab test. The barrier of the lab list prevents me from meeting my mandate of screening patients.

So what's the solution? The solution is to adopt the college of nurses' recommendation. In 2006, the College of Nurses of Ontario proposed the following amendments to the Nursing Act: The RN(EC)/NP has the authority to prescribe, dispense, sell or compound a drug, removing any reference to drug category, scheduling or a list in regulation. This amendment "would allow the RN(EC) the authority to openly prescribe, which enables the nurse practitioner to meet the needs of their client and keep pace with current practices"—College of Nurses of Ontario, 2006, page 3.

The College of Nurses also requests that the requirements for the performance and ordering of controlled acts be detailed in standards of practice of the RN(EC) and not in the regulations. This will remove the laborious process of amending the act when a revision to a drug category and lab lists is required for improved patient care.

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Now I'd like to speak to the myths or the fears around a nurse practitioner being able to openly prescribe. One is that open prescribing for NPs is new, that patient safety would be jeopardized, and that it also changes the focus of nursing.

Nurse practitioners prescribing can be traced back to the early 1990s when it was becoming increasingly acknowledged that nurse practitioners were being held back by their lack of prescription authorities; this is from Culley, cited in Wilson and Bunnell. In over half of the states in the United States, NPs have open prescribing authority to prescribe all medications; this is Running, Kipp and Mercer, 2006.

Since May 2006, British nurse practitioners have had the majority of their prescribing restrictions removed and

are able to prescribe all medications, except for some controlled medications—cited in Wilson and Bunnell.

Unlike Ontario, which has a list of medications and conditions in which the NP can prescribe, the College of Registered Nurses of British Columbia has developed a very short list of drug restrictions that the NP cannot prescribe. This gives the BC NP the flexibility to prescribe broadly in order to meet the needs of the patients. The Northwest Territories, Newfoundland and Labrador, and Nova Scotia can also prescribe very broadly.

Patient safety is a paramount goal of the NP. According to Carryer et al., 2007, such fears of patient safety are unsubstantiated in any scientific literature.

Why is it safe for NPs to prescribe? It's because we are highly trained in advanced practice and prescribing, according to Wilson and Bunnell, 2007.

In Ontario, the nurse practitioner is trained in therapeutics—prescribing medications and counselling—and must successfully complete the COUPN exam, the provincial exam, and then another 1,800-hour review proving their competency to practise as a nurse practitioner, including diagnosing and prescribing medications. This is from the College of Nurses, 2007.

An increasing number of NPs, like myself, are master's-prepared. We're also mandated by our college to be continuous learners.

It has been found that NPs have similar prescribing habits and outcomes as physicians. This speaks to places that have nurse practitioners who are openly prescribing. According to Moody, Smith and Glen, cited in Running, 2006, who have researched nurse practitioners' prescribing habits, physicians' and nurse practitioners' choices of medications, diagnostic screening and diagnoses were very similar. The differences they found: The NPs were more likely to provide teaching and counselling as their most common therapeutic service.

In summary, the studies show that NPs are cautious, competent and safe prescribers. They have similar prescribing patterns to physicians and achieve comparable outcomes; this is Wilson and Bunnell, 2007.

Nurse practitioners openly prescribing does not change the focus of nursing. Carryer, Gardner, Dunn and Gardner, in 2007, found that the additional function of ordering diagnostic tests and prescribing does not change the focus of nursing but actually improves access to services by allowing the NP to provide the full exposure of care. This is our goal with this bill.

The NP continues to focus on illness prevention, health promotion, education and follow-up compliance—Running et al., 2006.

What are the benefits of adopting the College of Nurses' proposal? You're going to have increased access to care. Having nurse practitioners prescribe and order diagnostic tests builds capacity—that's what we're trying to do—into the service, therefore increasing access to care. The NP who can openly prescribe according to her skills, experience and knowledge will instantly increase access to care by speeding up the treatment process and patient comfort.

In conclusion, NPs who openly prescribe do so safely, appropriately and cautiously while still maintaining a nursing focus of health promotion and disease prevention. It's time to adopt the recommendations of the College of Nurses of Ontario, which is to amend the Nursing Act to allow the nurse practitioner to openly prescribe and order diagnostic testing that is appropriate; also, that the requirements for the performance and ordering of controlled acts be detailed in standard practice and not in regulation. This change will allow for greater flexibility and independence in meeting the needs of the evolving health care system—

**The Chair:** I'm sorry. You're a fast talker, but I'm sorry.

**Ms. Allen-Fogarty:** Thank you for the opportunity to speak to the committee.

**The Chair:** We have your written submission too. Thank you.

#### ONTARIO TRIAL LAWYERS ASSOCIATION

**The Chair:** The next presentation is the Ontario Trial Lawyers Association.

**Mr. Duncan Embury:** Good afternoon, members of the committee. My name is Duncan Embury. I'm on the board of directors of the Ontario Trial Lawyers Association. You may note that you don't have any written materials from us. They will be coming tomorrow, and I apologize for that.

The Ontario Trial Lawyers Association is an organization of plaintiff trial lawyers from across this province with 1,250 members. Our mission is to represent the interests of people who have been injured through the wrongs of another and to ensure access to justice in all facets.

A few weeks ago, our Minister of Health said that transparency is the dance partner of accountability. That, in our view, is what is required when one looks at amendments to the Regulated Health Professions Act—accountability and the transparency that's necessary to get us there. I want to make three points before you today in terms of where that transparency is lacking or where it could be improved.

HPRAC in 2001 encouraged public access to information about doctors from the college. Bill 171 goes partway there with the changes to section 23 of schedule 2 of that act, but in our submission it should go further. That provides that a public register, accessible to the public, contain certain information at the college. You will see when you get our written materials that we recommend that that register be broader than what is contained in the legislation. It should contain a reference to the status of all complaints against a physician or other health care practitioner upon final disposition. It should contain all oral or written cautions issued against a health care practitioner, the terms and conditions or limitations imposed against that practitioner, the results of negotiated resolutions that result in any sanction, relevant



findings from other regulatory agencies and, in our view, it should contain the disposition of all lawsuits.

We say this for this reason: The public is entitled to information. They can act on it, and they can act responsibly. There is no suggestion, nor is there any evidence, that they can't. A few recent examples that have made the headlines across this province are enough to show that the public, without that information, is placed at harm. The public should not be placed at harm; that's what accountability is all about.

As well, in section 26 of that same schedule there is reference to the fact that the panel may have reference to prior decisions, unless the decision was to take no further action. We say only this: That exception should be removed because if there is a history of complaints being made, that should inform the panel hearing it to act otherwise than they might if it was the first complaint. That's a good thing for Ontarians because it ensures that where there's a pattern of mismanagement or incompetence by a physician, it is picked up as quickly as practicable by the college and dealt with, rather than a situation where, as in some recent cases, over 10 serious complaints were made before any action was ever taken because the prior complaints were never looked at. People were injured, and they were injured very badly, as a result of that failure.

The last issue in terms of transparency that I point this committee to is subsection 36(3) of the Regulated Health Professions Act. It's a section that's in force now and it is one where, by way of this bill, no suggestion is being made to change it. It is a section that provides that no document, report or written communication prepared for the purpose of a college complaint, including the decision of the complaints committee of the college, is admissible in a civil proceeding. There is no other profession that has that immunity. There is no other province in which regulated health practitioners have that immunity other than this one. It has resulted, at least in one recent situation in the college, having found that a doctor was far below the standards of his practice.

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When the child who was injured as a result of that substandard practice went to trial to get compensation to which he was justly entitled, the court—having no reference, of course, nor being advised of what the doctor's own college, the people in the best position to assess the care, had found—found that the doctor met the standard of care. That child has no compensation and will never have compensation.

That is not an accountable system. There is every reason to suggest that the college has the expertise to properly investigate and regulate its own, and it has done so quite well. But to not allow that access to information, either to the public through the means of the register, to the courts or others, in order to allow a consistent system, is folly, in our view.

The last point I simply make is this: There is, in the proposed amendments, a suggestion to increase the timing through which complaints are dealt with from

what is currently 120 days to 150, plus 60 in the event that it's not decided within 150—so, to 210 days. There is, in our submission, no purpose to be gained by that; rather, it appears to be a result of the fact that certain complaints have not been dealt with historically within 120 days. We say only this: If there is undue delay in the system, then the system should be addressed rather than moving the goalposts, because that doesn't do Ontarians a service. They're entitled to a prompt response, and the college has the means to do it, and it should be left the way it is, with encouragement that they do so within those parameters.

There are further points raised in our written submissions. I hope you will find them useful, and I certainly thank you on behalf of the Ontario Trial Lawyers Association for the opportunity to address this committee.

**The Chair:** Thank you. There's time for one quick question per caucus. Ms. Martel.

**Ms. Martel:** What has been your experience with respect to decision-making in a timely and prompt way; i.e., in accordance with the law?

**Mr. Embury:** It very much depends. I can speak only anecdotally and personally to that. In a large number of complaints, the complaints committee has the expertise within the committee to address them. There are other situations where they require or request an independent assessor to review, and it is typically those situations that cause the delay, because of course there's someone else's schedule to be considered, and obviously those are situations of complexity. Perhaps the way to address that is to suggest that if there is an independent assessor, add 30 days or 60 days for that rather than change the entire process by what is now a 90-day change, in effect.

**The Chair:** Mr. Fonseca.

**Mr. Fonseca:** Thank you very much for your presentation. In this legislation we're looking to provide greater access to information to the public. Through the colleges, they would now be required to make sure the public has access to them for information in a timely manner; so, as soon as they ask for it of the college during regular work hours. They also have to put this information on their website.

Do you feel there are other measures that could be taken further, and what do you think of these ones?

**Mr. Embury:** I think those are probably very sufficient. I think, at this point, people use the website more than almost anything else. To us, it's a question of what information we are dictating to the college needs to be brought forward to the public. The public, as I say, in our view, has a right to know, and they are responsible people who can make competent decisions if given proper information.

**The Chair:** Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. This right to know—which is really important, I think, particularly in light of some of the media coverage where obviously individuals didn't have information:

How far do you think that right to know should go? There's always that fine balance.

**Mr. Embury:** It seems, in our submission, that it should include all complaints that have been made; the outcome of those complaints, whether positive, negative or otherwise; the results of negotiated deals; and lawsuits, because, at the end of the day, in our submission it will be the minority of physicians or other health care practitioners who say, "No, that's not okay. We can't have that." Most are absolutely okay, in our submission, with the public knowing what their track record is. They're entitled to know that information to make a competent decision.

**Mrs. Witmer:** Thank you very much.

#### ASSOCIATION FOR REGISTERED HOMEOPATHS OF ONTARIO

**The Chair:** The next presentation is the Association for Registered Homeopaths of Ontario. If you would state your name for Hansard, you have 10 minutes.

**Ms. Ghislaine Atkins:** Good afternoon, ladies and gentlemen. My name is Ghislaine Atkins. I am the president of the Association for Registered Homeopaths of Ontario. This association has been recently created by a group of homeopathic practitioners who had at the time also recently graduated. As we were entering a new career in a profession about to become regulated, we felt it was our duty to become involved in the regulation process in order to better ensure the protection of public health.

There are four topics that I would like to address today. The first is why homeopathy should be regulated. ARHO believes that there are direct and indirect risks of harm arising with homeopathic treatment when prescribed by a non-qualified practitioner, as a result of an incorrect assessment, failure to refer or fraud. Some examples of direct risks are adverse reaction and interference of remedies with non-compatible conventional drugs. Examples of indirect risks are wrong diagnoses; failure to identify a critical state of disease, which could lead to delay of effective therapy; disregarding contraindications; discontinuation; potentially hazardous diagnostic procedures; and interference of remedies with conventional treatments.

The second reason we believe homeopathy should be regulated is the increased demand of the public. Patients wish to take the lead in their own health care decisions, including treatment outside of traditional medicine. Therefore, there is an increased need for public accountability. Patients should have the confidence that those who provide their care are adequately trained; operate within an appropriate scope of practice, professional and ethical standards; and provide safe care.

To conclude on this topic, ARHO agrees with the HPRAC recommendation that statutory regulation under the RHPA represents the best approach to providing public protection, quality care and public accountability for the homeopathic profession.

The next topic is related to the detailed scope of practice. ARHO approves the HPRAC recommendation not to grant homeopaths access to the following controlled acts under RHPA: communicating a diagnosis; performing a procedure on tissue below the dermis; administering a substance via injection or inhalation; applying or ordering the application of a form of energy prescribed by the regulations under this act; and prescribing, selling and compounding drugs.

Similarly, ARHO believes that homeopathic doctors should not be engaged in a disease diagnosis approach. Homeopathy is a complementary and alternative system of medicine to conventional and other alternative medicines. Those conventional and other alternative medicines already have access to these acts, and those acts are out of the scope of homeopathic practice principles. Instead, ARHO suggests that an increased reliance on homeopathic medicine will encourage collaborative practice between homeopathy and conventional medicine.

The next topic is educational requirements. We believe there are two important principles associated with homeopathic medicine that need to be transmitted to future homeopaths. The first is understanding a disease, but most importantly, the various stages of a disease, in order to be able to identify the need for appropriate treatment and to understand the function and impact of modification in order to recognize what symptoms are drug-related.

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The second objective is to ensure that future homeopaths differentiate between common symptoms of a disease and those unique to these individuals. In other words, it is important that homeopath practitioners practise according to homeopathic medicine principles. To support those homeopathic medicine principles, specific educational requirements exist. I would recommend the following education standards as per the homeopathic standards issued by the Homeopathic Medical Council of Canada in 1999. Those standards require minimum hours of education in medical science courses provided by accredited teachers of medical science and according to the HMCC accreditation of teachers. Those are listed below.

Similarly, a minimum of hours of education in homeopathic courses, clinical externship and other related courses by accredited teachers of homeopathic science according to the HMCC accreditation of teachers are required. Those are also listed below for your information.

The last, but not least, concern touches on the remedies that homeopath practitioners should have access to and other alternative medicine and conventional medicine. The first one is that the prescription of remedies of a 200 CH potency and up and certain low dilutions as stated in the Homeopathic Pharmacopoeia of the US be the exclusive jurisdiction of homeopathic doctors and other health care professionals properly trained in homeopathy.



The second item is that remedies made from narcotics, biological poisons, venoms and diseased human tissue be granted as the exclusive domain of homeopathic doctors and other health care professionals properly trained in homeopathy.

I will end this presentation with a couple of words on the future. The Association of Registered Homeopaths of Ontario would be pleased to assist and volunteer in the further development and implementation process of the regulation of homeopathy or in any other associated activities. Thank you for your attention.

**The Chair:** Thank you. There is time for 40 seconds per caucus, starting with the government.

**Mr. Kuldip Kular (Bramalea-Gore-Malton-Springdale):** First of all, thank you very much for coming out and taking time to present before the committee. I'm a medical doctor turned politician, so I have two questions for you. The first question is: What's your opinion of having a common college of naturopaths and homeopaths? You said you recently formed this association. How long has this association been in existence; how many months, how many days?

**Ms. Atkins:** To answer the first question, I believe it is a good thing that naturopathy and homeopathy are regulated under the same college as long as, as the previous speaker mentioned, they are still separated into individual colleges.

Secondly, the association was created in December 2006.

**The Chair:** Thank you. Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. I see that there is some difference of opinion amongst some of the homeopaths. You've indicated here that you agree with the recommendation not to grant access to the following five controlled acts. Do you want to explain exactly why you feel that way?

**Ms. Atkins:** We believe that this is out of the scope of the homeopathic principles. There are conventional medicine professionals and other alternative professionals who have access to those acts, and the opinion of the association is that we should work together and not try to go on to the practice of something that we haven't been properly trained for.

**Mrs. Witmer:** So the key is "not properly trained for"?

**Ms. Atkins:** Right. So we do have a certain education, but not enough to give us this ability.

**The Chair:** Ms. Martel.

**Ms. Martel:** We do note the differences, but that's why it's good to have public hearings. That's what it's all about. I just want some clarification around the college, because the current proposal is a dual college.

**Ms. Atkins:** That's right.

**Ms. Martel:** So is your association in favour of that, or do you want a separate college? I didn't clearly understand the previous response.

**Ms. Atkins:** The same college is fine as long as, again, the rules that will govern education for both practitioners, naturopathy and homeopathy, are different.

**Ms. Martel:** So your concern is around the educational qualifications of the practitioners.

**Ms. Atkins:** Absolutely.

**The Chair:** We're out of time.

## NORTH AMERICAN SOCIETY OF HOMEOPATHS

**The Chair:** I would call now for the North American Society of Homeopaths. You have 10 minutes. Please state your name first for Hansard.

**Mr. Basil Ziv:** My name is Basil Ziv, and I'm here with my colleague Jim Roy. We very much appreciate the opportunity of meeting with you today. We are here to convey the significant concerns of many in the homeopathic community concerning the proposed Naturopathy and Homeopathy Act in schedule P of Bill 171, the Health System Improvements Act.

Jim Roy and I are members of NASH, the North American Society of Homeopaths. I practise homeopathy here in Toronto and am board-certified. Jim has extensive experience as a management consultant and is a student of homeopathy.

Since 1990, NASH has pioneered the concept of voluntary self-regulation. Accordingly, NASH-registered homeopaths adhere to a strict code of ethics. NASH has advised a number of jurisdictions across North America on how best to foster self-regulation.

Jim and I have been involved in facilitating discussions among different groups in the Ontario homeopathic community regarding this regulation project and have met with officials of HPRAC. As well, I assisted NASH in conducting a survey of 10 homeopathic associations and schools operating in Ontario and a number of individual homeopaths to get their feedback on the Ministry of Health's decision to regulate homeopathy and compel us to enter into an arranged marriage with the naturopaths.

Before we provide you with NASH's feedback on the Ministry of Education's decision, I would like to take a few moments to share with you our understanding of what homeopathy is, its uniqueness and its place in the overall health system. Mahatma Gandhi, who saw the impact of homeopathy on a large percentage of the population of India, said, "Homeopathy cures a larger percentage of cases than any other method of treatment and is beyond all doubt safer, more economical, and the most complete medical science."

If you're not already familiar with homeopathy, this may appear to be an audacious statement, but bear with me. I will explain it, and you will see how this vision of homeopathy guides our perspective on the regulation project and our recommendations.

What Dr. Samuel Hahnemann, the founder of homeopathy, revealed some 200 years ago in the *Organon of Medicine* was a revolutionary method of treatment which focused on the core complaint of the patient and found a remedy that would bring the patient safely to a complete state of cure. This is radically different from other

healing modalities, which are focused on the management or elimination of certain symptoms without curing the whole patient. Homeopaths bring their patients to a complete state of health using safe and inexpensive remedies taken from the animal, plant and mineral kingdoms. This is certainly the most economic way of dealing with the serious and chronic health challenges faced by so many in the population, which place an enormous burden on our publicly funded health system.

I would now like to call on Jim to share with you our feedback and recommendations.

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**Mr. Jim Roy:** As mentioned by Basil, we've been very much involved. We have a homeopathic community which, you all realize, is quite split. We worked in a coalition, trying to bring some understanding and to work with HPRAC. Unfortunately, we have to say that we feel that the HPRAC process, in regard to homeopathy, was flawed really due to, I think, a lack of adequate resources and time and the complexity of the issue that they've had to face. They haven't been able to keep to their published principles and processes. This would be, I would say, one situation where public consultations would have been essential. Why? Because they're coming up with a proposal which is not what came from either the consensus of the community or even one group in the community. They had solicited the Ontario Homeopathic Association to put in a proposal, and yet what we've seen coming out of this is actually HPRAC picking up another proposal and adjusting it from the naturopaths, in which they've indicated that, frankly, another health care profession distinctly different from our own is going to be given a role of stewardship over our own profession.

Ontario homeopaths, under common law, have the right to practise their profession even in the absence of statutory regulation, as long as their occupation does not present a substantial risk of harm. Like all healing professions, the homeopathic practice is an occupation of common right. We contend that HPRAC has failed to prove scientifically that the homeopathic profession meets the first criterion under the Regulated Health Professions Act, namely, that it's a modality which would pose a substantial risk to a patient if exercised by an unqualified practitioner.

We do not, though, oppose in principle statutory regulation for a new model of primary care practitioner which includes homeopathy. Therefore, we would also add on some of the controlled acts, and you can see that there's an argument as to which of the controlled acts. I think that speaks to the real point we're all trying to get to: What is the definition of a profession? Because we're not regulated—and these are critical, that they'll make us regulated—and we have significant differences, it's really pick and choose as to which ones they want to put in. Frankly, we feel that the critical reason is simply to trigger regulation, as opposed to improving homeopathy and the care we offer to people and, certainly, the protection to the patients.

What we strongly object to, though, is the redefinition of the existing model of homeopathy in order to require all homeopaths to become primary care practitioners and therefore to be brought under statutory regulation. We really see ourselves in partnership with medical doctors and naturopathic doctors. In our own code of ethics and that of other associations, we have to advise the patient, "Make sure you've got a doctor. Make sure you get a diagnosis. Make sure that your case is being properly managed." We have a wonderful health care system in this province which provides for that and even provides it free of charge. So we want to work together; we do work together with these other practitioners.

We feel, therefore, that HPRAC has failed to prove that criterion number 7 of the RHPA has been met, namely, that such a redefinition and decision to regulate has the support of the majority of our profession. I think today it has been proven to you. We estimate that there's a minority of approximately 200 homeopaths—the OHA was here; we have the most recent, newly-brought-in group. They're part of that camp, so to speak, that seeks to become primary care practitioners with the controlled acts. There is a majority of approximately 700 homeopaths who are happily performing homeopathy and curing patients without access to the controlled acts.

**The Chair:** One minute.

**Mr. Roy:** Basically, then, we would ask that there be amendments made to the act. We certainly would want to see the naturopaths and the homeopaths separated, because there are clearly different distinctions, and there are Competition Act issues that you'd have to watch for. But most importantly, we would like the homeopaths to be able to continue in our path of self-regulation, where we certify our people according to international standards.

Thank you.

**The Chair:** Thank you. There about 30 seconds for the three parties, so is there one question out of—

**Mrs. Witmer:** No; I'd just like to make a comment. You've identified an issue which is of big concern to myself and our party, and that is the lack of consultation on such a huge piece of legislation. As we listen to you today and all the submissions come into our offices—we are trying to do so much in this huge omnibus bill. My major concern is that we will not get it right, and the people who are going to suffer are the people in the province of Ontario. To be quite truthful, I don't feel I'm in a position to make some of these decisions, and I believe that there are experts who need to make some of these decisions. So I think we're going to end up with a bill that obviously doesn't meet the public safety needs.

**Mr. Roy:** We would—

**The Chair:** I'm sorry. We're out of time.

**Mr. Roy:** Thank you very much.

#### PERTH DISTRICT HEALTH UNIT

**The Chair:** The last presentation is Perth District Health Unit. I always confuse the town of Perth with the county of Perth. Are you the county of Perth?



**Dr. Rosana Pellizzari:** We're the county of Perth; that's correct.

**The Chair:** Okay. Thank you. I'm more familiar with eastern Ontario.

**Dr. Pellizzari:** You must come and visit us some time.

**The Chair:** Thank you. You have 10 minutes.

**Dr. Pellizzari:** Good afternoon. My name is Dr. Rosana Pellizzari. I am the medical officer of health for the Perth District Health Unit, based in Stratford, Ontario. I'm here today on behalf of the Perth district board of health, which in March 2007 passed a resolution calling for an amendment to the Immunization of School Pupils Act. Efforts by Ontario's public health units to ensure that all children receive publicly funded and mandated immunizations in a timely fashion are hampered by legislation that is out of date. Since Bill 171, in schedule E, proposes changes to the Immunization of School Pupils Act that would allow nurse practitioners to immunize, my board of health is advocating for one additional change that would significantly improve the public health sector's ability to protect the public.

The Immunization of School Pupils Act was enacted to increase the protection of children against certain designated and vaccine-preventable diseases. Under this legislation, parents, with certain exemptions, are required to cause pupils to complete a prescribed program of immunization related to these six designated diseases. Contravention of this requirement is an offence and could lead to a fine of up to \$1,000.

As part of the Immunization of School Pupils Act, medical officers of health are required to maintain records of immunization of pupils and to keep under review a record of pupils who have not completed the prescribed program of immunization. Such pupils are subject to temporary suspension from school if parents have not complied with the legislation or even exclusion in the event of a potential or actual outbreak of one of the designated diseases. You may recall that when Oxford county had its rubella outbreak, in fact there were students who were excluded from school because they were susceptible.

Ontario children begin their immunizations at two months of age, with the bulk of publicly funded vaccines being administered before 18 months.

Physicians who provide immunization to children are required to provide parents with a signed statement of the vaccines given, and although not specifically referenced in legislation, parents are expected to provide this to the medical officer of health at the time of school entry.

Although the majority of vaccines are required to be administered prior to the second birthday, school entry occurs at about the age of four to five, some two to three years after the time of the immunization or when it should have been provided. Such a delay in the transfer of immunization information can and does sometimes result in a complete loss of the required documentation, incomplete transfer of information and delay in receipt of protection by immunization. Parental attempts to obtain

copies of immunization records can be thwarted by loss of physician records, retirement and relocation of physicians, and this may require parents to pay additional fees. Failure to obtain copies of lost records can subject schoolchildren to school suspensions, exclusions, repeat immunization and otherwise unnecessary blood testing or unwarranted exemptions. Just last week, I had to write a letter to one of our retired community physicians threatening to make a complaint to the college in order to expedite release of records to parents who had exhausted their efforts to obtain immunization histories for their children.

Vaccines are provided to physicians by the health unit at no direct cost to the physicians, and physicians are paid through OHIP for the giving of immunizations. It certainly seems fitting that a bill to improve the health system not overlook an opportunity to improve the existing system of preventing vaccine-preventable illness in our children, schools and communities.

Under section 38 of the Health Protection and Promotion Act, physicians who provide immunization are required to advise the person providing consent that they should report any adverse reaction to the vaccine to the physician, and they, in turn, are required to report this to the medical officer of health. Section 10 of the Immunization of School Pupils Act currently states that every physician who administers a vaccine to a child shall provide the parent with a signed record.

Ironically, however, physicians are not required to report the fact of the administration of any vaccine to a child to the medical officer of health, nor to seek the consent of the parent to provide information regarding immunization to the local medical officer of health. Your proposed amendments in schedule E fail to address this fundamental flaw in the original legislation. Left as is, if your bill becomes law, the non-reporting of my primary care physician colleagues will only be compounded by the non-reporting of another regulated health profession.

The current method of data collection relating to the immunization of children in Ontario, as I have explained, is inefficient, ineffective and results in added public health costs. While the province has been considering better data collection for almost 20 years through the introduction of vaccine-specific billing codes, this has not occurred and is likely becoming less possible with the continuing increase in the number of vaccines and their many combinations. There's been considerable discussion regarding the value of electronic medical records for all Ontario residents and the sharing of information amongst all health professionals. Such an ideal is unlikely to be available across the province for a considerable time and, even when available, will still require some level of consent for the sharing of information.

The province has an opportunity, by amending section 10 of the Immunization of School Pupils Act through Bill 171, to improve the protection of children from vaccine-preventable diseases, reduce the potential for suspension or exclusion of children from school and improve the effectiveness and efficiency of data collection for im-

munization by medical officers of health. This could be easily accomplished by the amendment of section 10 of the Immunization of School Pupils Act so that any professional administering a vaccine for protection against a designated disease would be required to seek consent for the reporting of the immunization, and with such consent be required to report the immunization to the medical officer of health.

This past January in Perth county, our health unit sent a letter to 343 students and their families, warning them of impending suspension due to deficiencies in immunization. That represents almost 4% of our total student body in the county. First letters are followed by second letters; second letters are accompanied by faxes to physicians with a request for assistance. All this work eventually identified that almost 75% of these children had already had their immunizations and were in fact up to date.

The real problem was that immunization records were missing or out of date, and until physicians and nurses

are required to report, we in this province will continue to spin our wheels, waste time and energy and potentially disrupt the learning of our children, unless we fix the fundamental problem once and for all through a very simple amendment to the Immunization of School Pupils Act. That is what my board is requesting, in addition to your proposed amendments in schedule E. Although simple to do, this change would be by no means trivial. It would in fact unfetter significant public health resources that are currently consumed in chasing missing records so that we in public health could reallocate these very scarce resources to emerging public health issues such as environmental protection and emergency response. Thank you.

**The Chair:** Thank you. There is no time for questions.

It now being precisely 6 o'clock, this committee stands adjourned until 3:30. Just a reminder to committee members that we will be in room 151 tomorrow.

*The committee adjourned at 1814.*



## **STANDING COMMITTEE ON SOCIAL POLICY**

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Mrs. Elizabeth Witmer (Kitchener–Waterloo PC)

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Second Session, 38<sup>th</sup> Parliament

**Assemblée législative  
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**Official Report  
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(Hansard)**

**Tuesday 24 April 2007**

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**Mardi 24 avril 2007**

**Standing committee on  
social policy**

**Health System  
Improvements Act, 2007**

**Comité permanent de  
la politique sociale**

**Loi de 2007 sur l'amélioration  
du système de santé**

Chair: Ernie Parsons  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Tuesday 24 April 2007

Mardi 24 avril 2007

*The committee met at 1559 in committee room 151.*HEALTH SYSTEM  
IMPROVEMENTS ACT, 2007LOI DE 2007 SUR L'AMÉLIORATION  
DU SYSTÈME DE SANTÉ

Consideration of Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts / Projet de loi 171, Loi visant à améliorer les systèmes de santé en modifiant ou en abrogeant divers textes de loi et en édictant certaines lois.

**The Chair (Mr. Ernie Parsons):** I would call the committee to order. I apologize for the late start. Question period went late today, and we are required to wait until the completion of petitions, which is another 15 minutes, so we are now at orders of the day. There is an overflow in committee room 2 for those unable to sit here, and I'm actually speaking to the wrong crowd when I say that.

Each presentation is 10 minutes. You're free to use up to 10. If you finish before the end of 10 minutes, the time will be divided equally between the three parties for questions.

ONTARIO ASSOCIATION  
OF SOCIAL WORKERS

**The Chair:** The first presentation is the Ontario Association of Social Workers. I would ask, once you are seated, if you would state your name for the purposes of Hansard.

**Ms. Joan MacKenzie Davies:** Good afternoon. My name is Joan MacKenzie Davies, and I'm the executive director of the Ontario Association of Social Workers.

OASW welcomes the opportunity to respond to a number of issues related to Bill 171. While our written submission addresses three significant issues—the exclusion of social workers from the Psychotherapy Act and use of the title “psychotherapist,” the amendment to the harm clause and restrictions on the use of the title “doctor” by health care professionals with earned doctorates—my oral presentation will focus solely on the Psychotherapy Act, which as currently drafted excludes social workers. This exclusion, as well as the actual wording of any amendment to the act, is of major concern to our organization.

I want to begin by noting that OASW has been working with the Ministry of Health to find an acceptable solution to address the social work profession's concerns. We also want to thank Minister Smitherman for publicly stating that he intends to present a legislative amendment that will recognize the profession and ensure that social workers can continue to provide important psychotherapy services.

Psychotherapy is a treatment intervention that is provided by practitioners from a diverse array of backgrounds. Among the existing regulated professions, social workers are in fact the largest professional group providing psychotherapy services in Ontario. Moreover, social workers provide psychotherapy services through a wide variety of funded settings and private practices, and in many small rural and remote communities, social workers are often the only profession providing these services.

HPRAC's New Directions report in April 2006 fully recognized social workers as one of the four regulated professions qualified to provide psychotherapy. OASW is very concerned that failure to recognize social workers as equal partners to the other professions authorized to provide psychotherapy will cause members of the public, employers and insurance companies to erroneously perceive our profession to be less qualified to provide these services than members of the existing regulated professions listed in the Psychotherapy Act along with members of the new College of Psychotherapists.

OASW has received legal opinions that confirm the fact that there is no impediment to government making an amendment to the Psychotherapy Act that acknowledges members of the Ontario College of Social Workers and Social Service Workers as qualified to perform psychotherapy. Based on our concern, OASW has proposed an amendment to the Psychotherapy Act that authorizes social workers to perform the controlled act of psychotherapy and recognizes social workers as equal partners to the other professions that are currently authorized to perform this controlled act. Wording for this amendment is provided in our written submission.

I will close by thanking you for this opportunity to comment on Bill 71.

**The Chair:** Good. We've got about a minute and a half for each caucus for questions. I forget where we finished yesterday, so I'm starting fresh. Mrs. Witmer.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** Thank you so much for your presentation. Certainly we

value very much the work of social workers and also their work in the delivery of psychotherapy services in the province of Ontario.

I've had a chance to hear from many of your members—in fact, I would have to say that your members have probably lobbied harder and more than almost anybody else on this bill in order to ensure that there was no exclusion of social workers. Are you, then, totally comfortable that any amendment that would be forthcoming from the government would be worded as you have indicated it should be here?

**Ms. MacKenzie Davies:** No, we have not seen wording at this point that would capture the full recognition of social workers as equal partners, and that's really what we're pressing for.

**Mrs. Witmer:** Right, but you feel that this particular amendment would do that?

**Ms. MacKenzie Davies:** Yes. We're seeking wording that would authorize us and would ensure that the public and employers—that it would be clear to everyone that it's equal and we're on equal footing.

**Mrs. Witmer:** And we wholeheartedly would support that. Certainly we would be putting forth that amendment ourselves to make sure that it was discussed and debated.

What about the doctor title? You didn't say anything about that. I've also received quite a bit of communication. I do have social work schools in my riding, and I'm very proud of the education they deliver to our students. Could you just expand on that, please?

**Ms. MacKenzie Davies:** We believe that use of the title "doctor" should be available to all health professionals who have earned doctorates and who are members of the regulatory college. Our research has indicated, and it was supported in the HPRAC New Directions report, that it really is an anomaly in Ontario, that it does not serve public protection, that in fact the public relies on information about credentials, whether it's a plumber, an accountant or someone who's providing important health care services, to know what their qualifications are. That informs choice.

**Mrs. Witmer:** So—

**The Chair:** I'm sorry. Ms. Martel.

**Ms. Shelley Martel (Nickel Belt):** Thank you for being here today. I was actually very surprised that social workers weren't included in the original bill, and I thank some of your members who sent good letters that I ended up using in the debate to show why this should be the case now.

I want to ask about what kinds of conversations you've had with the ministry since the minister announced the day the bill started that you were going to be included, and whether there is an amendment they have proposed to you that you feel comfortable is going to fix the problem.

**Ms. MacKenzie Davies:** We don't think that they're a long way off, but we would want to ensure that an amendment is worded in the positive so it authorizes us to perform the activity. We do not wish to be exempted in an amendment or have wording that would suggest

that there was anything less than full authorization, assuming of course that the individual was a member of the Ontario College of Social Work and Social Service Workers.

**Ms. Martel:** At present, you've seen an amendment. It is, I gather, more in a negative sense, as around an exemption, rather than positive. Have you gone back to the government to say, "This is not acceptable to us. Can we see some other language?"

**Ms. MacKenzie Davies:** Yes, and we've provided them with a copy of this amendment.

**Ms. Martel:** So the language you have given to them is the language that we have in the brief, and that's the one you'd like to see in the bill.

**Ms. MacKenzie Davies:** Yes.

**Ms. Martel:** Very good.

**Ms. MacKenzie Davies:** And from the onset, that has been our position, that it needs to be a positive authorization.

**The Chair:** Mr. Fonseca.

**Mr. Peter Fonseca (Mississauga East):** Thank you very much, Chair, and the Ontario Association of Social Workers. Firstly, it was always our intent to include social workers, but because it was outside the RHPA, we were going to do it in regulation. But we thank you very much for having so many of your members contact our offices and let us know your concerns.

I'll just read a couple of excerpts very quickly here from the letter that was forwarded to you by Minister Smitherman. He is very well "aware of the valuable contribution made by social workers to the delivery of psychotherapy services in Ontario." And then, just in his conclusion: We "will recognize the profession and ensure that those social workers who provide psychotherapy services associated with the new controlled act will continue to be able to provide these very important services" in the province.

We thank you and your 3,400 members for the great work that you do for all Ontarians.

**Ms. MacKenzie Davies:** Thank you.

**The Chair:** Thank you.

## ASSOCIATION OF ONTARIO MIDWIVES

**The Chair:** I would ask next for the Association of Ontario Midwives. If you would state your name for Hansard, please.

**Ms. Juana Berinstein:** Juana Berinstein, director of policy for the Association of Ontario Midwives.

**The Chair:** You have 10 minutes.

**Ms. Berinstein:** Thank you. The Association of Ontario Midwives, or the AOM, is pleased to have an opportunity to address the standing committee on social policy regarding Bill 171 today.

The AOM is the professional body representing midwives and the practice of midwifery in the province of Ontario. There are approximately 366 registered midwives in the province working in over 60 practice groups.



Midwives are autonomous primary care providers regulated and authorized to provide comprehensive care for low-risk pregnant women and newborns and to deliver in both home and hospital settings. Midwives consult with and refer to specialists if clinically indicated during the course of care.

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Our presentation today will focus on our support of changes in Bill 171 that allow for categories of drugs. These changes will have a positive effect on health care by allowing midwives to work fully within their scope, ensuring optimal client safety and best use of system resources.

The AOM strongly supports the addition of drug categories to regulations as outlined in schedule B, section 13, and again in the Midwifery Act, section 11. Currently, regulation limits midwives to a specified list of drugs. As I will explore in this presentation, limiting midwives to a specified list of drugs leads to numerous problems and inefficiencies. Enabling midwives to prescribe and administer drugs from categories, and not lists, is needed in order to enable midwives to provide safe and up-to-date care and in order to ensure an effective and efficient health system.

For the AOM, the addition of drug categories in Bill 171 is a very welcome initiative. In a discussion paper dated May 2004, the College of Midwives of Ontario outlines both potential categories for drugs as well as an approach for working with drug categories. The approach includes providing specific guidance to members on the use of drugs. We strongly feel that the specificity of drug use is best entrusted to the college. It is the college that is best situated to provide standards in which midwives may use drugs of a specific category, as well as recommendations for choice of drug.

Drug categories, for example, are regulated in midwifery legislation in Manitoba, which names categories of drugs in its regulation within the scope of providing maternity and newborn care. There has been no evidence of abuse of this authority. In fact, the scope of practice for midwives naturally limits the usage and prescription of proposed categories of drugs.

Legislating drug categories will more easily enable midwives to practise fully within the midwifery scope. Since legislation of midwifery and the initial development of regulations, there have been changes in the standard of care regarding medications used in the provision of maternity care. Drug categories would enable midwives to respond to such changes quickly and appropriately.

Further, within the context of a shortage of providers, it makes sense to support midwives in the provision of routine maternity care. Allowing for categories of drugs enables midwives to provide care within their scope without the unnecessary involvement of physicians. It allows for the right provider at the right time by freeing up physicians to consult on cases where they are truly needed and enabling midwives to work to their full scope as primary care providers.

Legislating drug categories ensures timely treatment and client safety. It permits midwives to avoid being placed in a situation where they cannot provide the appropriate standard of care to clients simply because government has not been able to amend regulated drug lists in a timely way. By allowing midwives access to drug categories, midwives are better able to provide safe and effective care when research evidence indicates new medications may be required.

As the example of ergonovine maleate demonstrates, listing drugs is simply too restrictive. Ergonovine was one of two medications to control postpartum hemorrhage listed in midwifery regulation and that the second-line drug midwives had available to address situations of postpartum hemorrhage. However, in 2004, due to a raw ingredient shortage, ergonovine was unavailable for a period of time. Again, a drug category of anti-hemorrhagics, versus the specific drug list, in this case ergonovine, would have meant that midwives could have easily switched to another anti-hemorrhage drug in the case of a shortage or unavailability.

Legislating drug categories enables access to timely care. Significant delays to treatment, and costs to the health care system, can occur when a physician consult is required due to restrictions created by regulation but not clinically necessary.

For example, upon routine urine culture to screen for asymptomatic urinary tract infection, UTI, a midwife may find a positive culture. The medical literature indicates that asymptomatic UTI in pregnancy should be treated. Currently, in order to access treatment in this situation for her client, a midwife must call the client and ask her to book an appointment to see her family doctor or to go to a walk-in clinic if she doesn't have a family doctor. The midwife will fax the lab report and a consult letter outlining the need for treatment of asymptomatic UTI in pregnancy to the family doctor or clinic. The client sees her doctor for treatment, and three weeks later she returns to the midwife for a routine prenatal visit. The midwife, who has reasonably assumed that the doctor has prescribed the appropriate treatment for the UTI, discovers that the family doctor, who likely doesn't practise obstetrics, has indicated to the client that they do not treat asymptomatic UTI. The midwife must then consult again with the doctor or walk-in clinic to ensure adequate treatment of UTI. Considering that the risk in pregnancy of asymptomatic UTI left untreated is ascending infection, this lack of timely access is a client safety issue.

Legislating drug categories will support interprofessional relationships. A common intrapartum issue is the prophylactic treatment for women in labour who have a positive group B streptococcus or GBS screen. The standard of care in most communities is to offer every woman who has screened positive for GBS antibiotics in active labour. While midwives can administer this treatment, they are unable to order the necessary drug to ensure prophylaxis under their own authority. As is the way with birth, active labour so often occurs outside of daytime hours.

Currently, this means that midwives must wake their obstetric colleagues from much-needed sleep every time they have a client requiring GBS prophylaxis, in order to be able to access the medication required. This is disruptive to the obstetrician on call, an unnecessary added cost to the system and an unnecessary delay in treatment. Such restrictions have the potential to undermine inter-professional collaboration.

Legislating drug categories enables the college, and by extension, practitioners, to respond to ongoing changes in the standard of care in obstetrics in a timely way. For example, in August 2006, research published by Dr. Gideon Koren in the *Journal of Obstetrics and Gynaecology Canada* demonstrated that maternal consumption of folic acid containing prenatal multivitamins was associated with a decreased risk for several congenital anomalies, including neural tube defects. Since then, *Motherisk*, a program at the Hospital for Sick Children and a leading national authority on pregnancy information, recommends a dosage of five milligrams of folic acid per day for all pregnant women. However, midwives in Ontario are limited to prescribing no more than one milligram of folic acid. Women under midwifery care will now need to go to their family doctor or a walk-in clinic to get a folic acid prescription. Last year, midwives cared for approximately 10,000 women.

It can cost approximately \$30 for a physician to see a woman, repeat the assessment made by the midwife and write a prescription, and that's likely a conservative number. That's a cost of \$300,000 for the health system that is spent on appointments that are not clinically necessary. This is an unnecessary cost to the system and exacerbates the shortage of family physicians. Drug lists create these kinds of health system redundancies. They make what should be a simple and straightforward process into an unnecessarily complex process.

**The Chair:** I'm sorry, but I have to be ruthless on this.

**Ms. Berinstein:** That's fine. I have distributed the submission.

**The Chair:** We have the written copies and they certainly will be read. We appreciate your being here.

#### AGENCY IMPLEMENTATION TASK FORCE

**The Chair:** The next presentation is Cancer Care Ontario. I would remind you that there is an overflow in committee room 2, with seating and television broadcasting this, if you wish.

**Dr. Terry Sullivan:** My name is Terry Sullivan. I'm the president and chief executive officer of Cancer Care Ontario. Thank you for allowing me to appear this afternoon. I should say that I am appearing here in my capacity as co-chair of the agency implementation task force, and my remarks will focus exclusively on schedule K of this bill, dealing with the Ontario Agency for Health Protection and Promotion Act.

My co-chair, Dr. Geoff Dunkley, is unable to join me here today because he's practising in Mali, Africa, at the

moment. But I'm speaking here with the support of all members of our agency implementation task force.

This task force was struck in 2004, in direct response to recommendations arising from the expert panel on SARS and infectious disease control, to provide advice to the Ministry of Health and Long-Term Care on the design, development and implementation of a public health protection and promotion agency.

I should say to you that in addition to my day role, I'm a behavioural scientist, and I have a faculty appointment in public health sciences and in health policy management evaluation at the University of Toronto.

The task force reported to the chief medical officer of health and, through her, to the Minister of Health. The minister and the chief medical officer of health appointed the members of the task force, and the membership included national experts in public health, a representative from the Public Health Agency of Canada and individuals with expertise in a range of functional areas of the agency, including research, infectious disease control, health protection, zoonotic diseases etc.

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The task force delivered an interim report to the ministry in October 2005 and its final report in March 2006. The chief medical officer of health endorsed and accepted the report on behalf of the ministry, and the task force recommendations regarding the governance model, as reflected in these remarks, have also been endorsed by Dean Walker, who chaired the expert panel on SARS and infectious disease control.

In assembling its recommendations, the task force used a range of approaches, including reviews of the scientific literature, analyses of jurisdictions elsewhere and an examination of best practices in a range of areas related to public health agencies. We developed a governance structure, we consulted with experts in governance, we looked at governance models in place for a range of public health agencies in other jurisdictions, and we held discussions with key leads in research and health sector agencies in Ontario and across Canada.

Let me say a little, then, about the governance model for the agency. Consistent with the task force recommendations and the Walker report, the act proposes that the agency be established with an arm's-length relationship to government. The arm's-length model is consistent with the structure in place at the BC Centre for Disease Control and the Institut national de santé publique du Québec. It is noted that these agencies were cited by the late Justice Campbell as models for an Ontario agency and in the first interim report of the independent SARS commission, SARS and Public Health in Ontario.

As a crown agency, the organization would operate independently from direct government control, yet remain accountable to the Minister of Health and Long-Term Care for its activities, and ultimately to the Legislature, through adherence to Management Board directives for crown agencies and a memorandum of understanding to be entered into between the agency and the ministry.



The task force suggested that the proposed crown agency status for the organization set out in the act reflects the appropriate balance between independence and accountability.

The task force also supports a very active role for the chief medical officer of health in the agency's governance structure as set out in the act.

The act provides that the CMOH or designate be entitled to attend any meeting of the agency's board of directors and participate in such meeting to the extent that the board may allow. The CMOH is to be provided with reasonable notice of all board meetings and copied with the meeting materials. The act further provides that the board shall not unreasonably limit the participation of the chief medical officer of health at all board meetings.

In deliberating the governance model for the agency, the task force concluded that the chief medical officer of health should not be a formal voting member, as this would represent a serious conflict of interest. The CMOH also serves as the ADM for public health within the ministry and would have controllership in relation to the funding for the agency. As ADM, the CMOH would also be privy to confidential decisions with respect to the ministry determinations that might directly affect the agency beyond issues of funding. The task force concluded that it is contrary to good governance principles for the chief medical officer of health to be both accountable to the ministry for the operations of the agency and a member of the agency's board, with its consequent fiduciary obligations.

The act further provides that the chief medical officer of health, by virtue of office, is a member of the agency's strategic planning committee responsible for setting priorities for the agency, and ultimately that the chief medical officer of health play a key role in aligning these priorities from a funding point of view with the ministry. The chief medical officer of health is responsible for leading interministerial committees and would have a process for ensuring that government-wide priorities are brought forward to the agency's planning standing committee and aligned with the agency's activities with respect to its annual budget negotiations. By virtue of the status of the CMOH at the board and membership on the planning committee, there are clear channels to provide input into the ongoing work and provide overall direction of the agency.

Finally, let me say something about emergency readiness and response. Consistent with the task force recommendations, the act provides that the CMOH has the power to mobilize the resources of the agency to provide scientific and technical advice and operational support in any emergency or outbreak situation with health implications. This is an important power, because it ensures that the CMOH has ready access to a pool of highly skilled scientific and technical areas of specialization during times of a public health emergency. The explicit directive-making authority of the CMOH over the agency's resources is a far stronger lever of control than any seat on the board.

The power of the chief medical officer of health to issue directives in times of emergency ensures that the agency is working within the chain of command established within the province and the ministry during such events. This will help to ensure that there are clear lines of communication, clarity of roles and responsibility, and coordination among the various players during an outbreak.

As the objects of the agency make clear, the supporting role to be played by the agency in times of emergency or outbreak is just one aspect of the broad mandate in public health. The agency has a role in surveillance, epidemiology, research, knowledge exchange, laboratory medicine, professional development and communication. One of the key components of the agency's work will be reforming and strengthening of the Ontario public health laboratory system. This is a broad scope of work that must be led by a full-time, experienced CEO with an international reputation and a mandate autonomous from government. The autonomy of the agency and its CEO, real and perceived, is critical to the ability to carry out its objects and recruit, frankly, first-class researchers and scientists, and build relationships with the best and brightest public health scientists in Ontario institutions and beyond.

Thank you very much for the opportunity to present these remarks. Just to summarize, we fully support the establishment of the dedicated agency as laid out in the statute, and the establishment of this agency is critical and very welcome to advance the state of public health knowledge and practice for Ontario and for Canada. We fully support the governance model set out in the act for this agency. We submit that it strikes the right balance between autonomy and accountability, ensuring the alignment of the agency's work with the ministry and ensuring that the CMOH can mobilize the agency during times of a public health emergency.

Thank you very much, Mr. Chair.

**The Chair:** Thank you very much. We appreciate you being with us. There is no time for questions. I'm sorry. I'm thinking of trying this technique at home with our nine- and 10-year-olds.

**Dr. Sullivan:** Okay. Thank you.

#### REGROUPEMENT DES INTERVENANTES ET INTERVENANTS FRANCOPHONES EN SANTÉ ET EN SERVICES SOCIAUX DE L'ONTARIO

**The Chair:** The next presentation is en français. I'm an engineer by training. I can butcher the English language quite easily, and the French language is far too beautiful for me to attempt it and mispronounce it. So I would ask the next group to come forward. For committee members who require translation, these are not iPods but—

**M<sup>me</sup> Christiane Fontaine:** Monsieur le Président, membres du comité, mon nom est Christiane Fontaine et

je suis la directrice générale au Regroupement des intervenants francophones en santé et en services sociaux de l'Ontario, le RIFSSSO. Premièrement, j'aimerais vous remercier de m'avoir accordé quelques minutes afin de vous demander des modifications à l'article 69 de l'annexe M du projet de loi 171.

Le RIFSSSO est un organisme provincial qui regroupe plus de 4 000 professionnels francophones provenant des quatre coins de la province. Il est actif dans le dossier de l'identification des professionnels de la santé aptes à offrir des services et des soins de santé en français principalement depuis les cinq dernières années. Il a fait plusieurs interventions auprès des ordres réglementés en santé afin qu'ils développent un mécanisme de cueillette de données qui permettrait l'identification de ces professionnels.

Nous savons tous que les professionnels de la santé sont les piliers de notre système de santé. D'ailleurs, l'accessibilité à des services de santé dans sa langue constitue par le fait même bien plus que le respect de la culture pour l'utilisateur de services. Il s'agit d'un élément essentiel à l'amélioration des conditions de la santé et à l'appropriation de la santé par la communauté.

Une prestation de qualité est aussi étroitement associée à la capacité des professionnels à promouvoir la santé, à faire des diagnostics et interventions efficaces, à offrir des traitements et à assurer des services auprès des utilisateurs.

Pourquoi est-ce donc si difficile d'obtenir des services en français en Ontario? Certainement, il existe des professionnels francophones travaillant dans nos différents organismes de la santé. Le problème, c'est qu'ils ne sont pas identifiés comme tels. Ils se retrouveraient isolés au sein de leur établissement ainsi que leur association ou ordre professionnel pour lesquels les services de santé en français ne sont pas une priorité de premier ordre.

D'ailleurs, plusieurs études ont démontré que les barrières linguistiques proviennent du fait que l'utilisateur de services de santé et le professionnel ne parlent pas la même langue. Dans notre cas, l'insuffisance du niveau d'anglais de l'utilisateur peut causer certains problèmes et peut même avoir des répercussions graves sur sa santé.

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L'accès aux services de santé dans sa propre langue est d'ailleurs considéré comme un facteur-clé de l'efficacité des soins et traitements reçus. Les barrières linguistiques ont un effet défavorable sur l'accès initial avec le professionnel. D'autres études démontrent que les patients qui ont de la difficulté à s'exprimer en anglais, dans notre cas, ont un taux d'utilisation des services d'urgence plus élevé et leur état de santé est plus précaire car ils ont recours tardif à des services de spécialistes ou de diagnostics. Ils ont également un accès réduit aux services de santé mentale et de counseling, qui sont offerts majoritairement en anglais ici en Ontario.

Le manque de communication avec le professionnel peut même occasionner une baisse de l'utilisation de services préventifs, comme c'est le cas de la mammo-

graphie chez les femmes francophones en Ontario. Il peut également augmenter le temps passé en consultation ou à subir des tests et des examens qui serviront à établir un diagnostic ou un traitement approprié.

En plus, une communication inadéquate augmente la probabilité de l'utilisateur de ne pas comprendre le traitement suggéré ou de suivre la podologie recommandée, et aussi, pour le professionnel, cela augmente la possibilité de faire un diagnostic erroné.

Présentement, l'identification des professionnels de la santé demeure en grande partie invisible. Si nous désirons avoir des données fiables, une action prioritaire doit être faite par notre gouvernement afin d'obliger les ordres réglementés de la santé à identifier leurs membres qui sont aptes à offrir des services professionnels de santé en français.

L'article 69 de l'annexe M du projet de loi 171 stipule que « L'ordre détermine et consigne la langue préférée de chacun de ses membres. » L'identification de la « langue préférée » n'est pas suffisante car elle propose un processus aléatoire d'identification de la langue du professionnel.

Nous demandons donc que cet article réfère aux « langues officielles utilisées par chacun des membres lors de l'offre des services » au lieu de « la langue préférée » comme mentionné dans l'article 69.

En bref, nous proposons que l'article 69 de l'annexe M du projet de loi 171 mentionne que « L'ordre identifie et consigne les langues officielles utilisées lors de l'offre des services pour chacun de ses membres ». De cette façon, la loi exigera des ordres réglementés de la santé de recueillir des données linguistiques sur les services de santé qui sont offerts dans les deux langues officielles par leurs membres. Nous aurons ainsi accès à des données fiables qui pourront ensuite être utilisées lors de la planification des ressources humaines en santé aptes à desservir la population francophone de l'Ontario.

Merci.

**Le Président:** Merci. We have about one minute per caucus, starting with Ms. Martel.

**M<sup>me</sup> Martel:** Merci pour être venue cet après-midi. Je voudrais demander pourquoi les mots « la langue préférée » ne sont pas suffisantes pour répondre à vos besoins. Je voudrais savoir la différence exacte à propos de « la langue préférée » et « les langues officielles utilisées ».

**M<sup>me</sup> Fontaine:** Pour nous, lors des interventions précédentes qu'on a eues avec les ordres, on nous disait qu'on identifiait la langue du professionnel parce qu'il a demandé de recevoir leur publication en français. On sait que sur leur terrain ou dans des organismes où ils travaillent, qui sont majoritairement anglophones, à ce moment-là ils vont demander d'avoir les communications en anglais. Donc, à ce moment-là, on perd tout de suite là l'identification de ce professionnel francophone. Donc, si on lui demande s'il est apte à offrir des services dans une des langues officielles ou dans les deux langues officielles, on a vraiment le professionnel qui peut offrir des services en anglais, naturellement, mais aussi en français.



Cela va aider au niveau de la planification des ressources humaines, surtout dans les régions où il y a beaucoup de pénurie. Ça va aussi appuyer le développement de nouveaux programmes de formation post-secondaire pour combler cette pénurie de personnel.

**M<sup>me</sup> Martel:** C'est à cause du fait qu'on a besoin d'une meilleure identification du nombre de professionnels?

**M<sup>me</sup> Fontaine:** Oui, un nouveau systématique. Donc, quelque chose de formel avec lequel les ordres pourront nous donner des rapports sur leurs membres qui peuvent offrir des services en français.

**M<sup>me</sup> Martel:** Okay, merci.

**M. Khalil Ramal (London-Fanshawe):** Merci beaucoup pour votre présentation. Je sais que cette loi reconnaît les langues officielles—le français et l'anglais—et je comprends que vous avez un problème avec l'article 69 qui parle de la langue préférée. Pourquoi?

**M<sup>me</sup> Fontaine:** Le problème que j'ai avec « la langue préférée », comme j'ai expliqué à M<sup>me</sup> Martel, c'est que ça ne permet pas d'avoir un mécanisme officiel au niveau du système qui permet d'identifier les professionnels qui offrent des services de santé ou des soins de santé en français. Ça permet aux ordres d'identifier les professionnels qui offrent des services en français de différentes façons, qui ne seraient pas la même façon dans tous les ordres. Ils peuvent demander des publications en anglais alors qu'ils sont aptes à offrir des services en français. Ils peuvent, par exemple, dans certaine cas leur demander si leur formation avait été en français, et c'est comme ça qu'on identifie les professionnels, mais on sait que dans la réalité, beaucoup de professionnels vont à des instituts comme McGill à Montréal ou Concordia, qui sont des institutions anglophones. Donc, ce n'est pas un processus qui nous donne des données fiables.

**M. Ramal:** Je pense qu'un autre officiel dans le ministère de la Santé a communiqué avec le peuple, spécialement de la communauté francophone de l'Ontario, en deux langues—like, an e-mail pour votre organisation en anglais, parce que c'est automatique, the e-mail system. Mais en général ils répondent en français et en anglais en même temps.

**M<sup>me</sup> Fontaine:** Parce que dans le passé, on a aussi communiqué avec l'Office des affaires francophones pour nous appuyer dans nos démarches et aussi, il y a eu des communications avec le ministre Smithernan pour lui faire part de nos préoccupations à ce niveau-là.

**M. Ramal:** Okay. Merci.

**The Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much for your presentation. I recognize the time is up.

**Le Président:** Merci.

#### BOARD OF DIRECTORS

#### OF DRUGLESS THERAPY–NATUROPATHY

**The Chair:** The next presentation is the Board of Directors of Drugless Therapy–Naturopathy.

**Ms. Angela Moore:** Good afternoon, Mr. Chair and members of the committee. My name is Angela Moore and I am the chair of the Board of Directors of Drugless Therapy–Naturopathy, the regulatory board for naturopathic doctors under the Drugless Practitioners Act. I'm also a naturopathic doctor, although I'm not in active practice at this time. Accompanying me is our public member, Marianne Park.

The naturopathic profession has been regulated in Ontario since 1923 and, as such, is one of the oldest regulated professions in the province. This means that the transition to the RHPA should be relatively smooth compared to professions that are being regulated for the first time. The board and the naturopathic profession are very supportive of regulation under the RHPA. The Drugless Practitioners Act is a seriously outdated piece of legislation. It does not allow the board to regulate the profession efficiently or effectively, or in a way that is compatible with the requirements of the RHPA. HPRAC has recommended the regulation of NDs under the RHPA three times, most recently in its New Directions report, issued last April. We are very pleased that that recommendation is finally being implemented.

Having said that, I'd like to raise a few issues with respect to Bill 171 that are of concern from a regulatory perspective. Each of our comments is motivated by a desire to continue the current scope of practice of naturopathic doctors in Ontario. In other words, we wish to ensure that under the RHPA, NDs can continue to offer patients the level of care they are receiving now under the Drugless Practitioners Act, and have been for some time. The ministry has repeatedly stated that this is their intention as well, and clearly HPRAC also agreed with this objective.

The first matter I'll address today is to confirm that NDs will have access to the natural substances they use for treating patients. This is rather complicated, because it relates to the intersection of federal and provincial laws with respect to the regulation of drugs.

Naturopathic doctors are educated in the use of a wide range of natural substances that they have prescribed, dispensed and compounded safely and effectively for years. Recently, however, as the federal government undertakes the regulation of natural health products, some natural substances that are not considered safe for the general public are being moved to prescription-only status on federal drug schedules. Federal law requires that prescriptions be issued by health care practitioners who have the specific authority to prescribe under provincial law. In Ontario, this authority is granted under the controlled acts set out in subsection 27(2)8 of the RHPA. On page 183 of the New Directions report, HPRAC states: that "optimal care cannot be offered to patients unless naturopathic doctors have access to substances consistent with naturopathic practice."

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Contrary to what HPRAC recommended, schedule P does not give the naturopathic profession the controlled act of prescribing. Instead, the ministry believes that it

can use the authorities under subsection 117(1) of the Drug and Pharmacies Regulation Act to, in effect, exempt the natural substances used by NDs from the prescription requirement in federal law.

Because of the importance of this issue, the board retained a legal counsel who is an acknowledged expert in this area. It is her view that the ministry's solution would be susceptible to successful challenge from the federal government that has jurisdictional primacy in this area.

Accordingly, to address any doubt or ambiguity, the board asks the committee to amend schedule P by giving naturopathic doctors prescribing authority as recommended by HPRAC, namely,

"That naturopaths be authorized to prescribe, dispense, sell and/or compound drugs that are consistent with naturopathic practice, as prescribed in regulations."

This is an issue of great concern for the naturopathic profession and for their patients. If NDs don't have access to these substances, patients will no longer be able to receive the care they are now receiving.

The second issue I want to address relates directly to regulatory effectiveness. Previously, when existing regulated professions were brought under the RHPA, the statutory regulatory bodies that existed pre-RHPA were legally continued as the new regulatory colleges under the profession-specific acts.

This is not the approach that's taken in schedule P, and it's going to cause problems if it goes ahead as it is now, because as soon as schedule P is proclaimed, the Drugless Practitioners Act and the board will cease to exist. This means that investigations, complaints and disciplinary procedures that are in process at that time would have to be abandoned. Neither the transition council nor the new College of Naturopaths and Homeopaths would have authority to complete those procedures. The old board would have no ability to enforce outstanding disciplinary actions. Basically, the old board would not be in existence anymore. The assets and liabilities of the board would not be transferred to the transitional council, nor to the ultimate college. Those assets include staff as well as our registration list and various databases that would be critically important to regulation of the profession after proclamation. I believe that committee members will agree that none of this would be in the public interest.

As schedule P is currently drafted, upon proclamation, the current officers and directors of the board would have to set about winding up the board. There would be no transition into the transition council or into the College of Naturopaths and Homeopaths.

Our discussions with the ministry have suggested very clearly that this is simply an oversight. We hope that the government will bring forward amendments to address this. Our written submission to the committee puts forward recommended wording to resolve this issue. That wording is based on the statutory formulations used previously under the RHPA.

Now I'd like to turn to the wording in schedule P relating to the authorized act of communicating a diag-

nosis. The board understands that both the wording and application of this controlled act raise a number of complex issues and interprofessional sensitivities.

However, we are concerned that the adjective "naturopathic," which is being used to modify diagnosis in paragraph 4(1)5, will result in difficulties. The other professions that have access to this controlled act don't have such a modifier in their authorized act statement. For example, there isn't a "dental" diagnosis or a "chiropractic" diagnosis or a "psychological" diagnosis, and it's not clear why there should be a "naturopathic" diagnosis. Our concern is that in future, this modifier will be interpreted to restrict the scope of naturopathic practice. Currently, NDs are required by the board to formulate diagnoses for all patients using the tools that are available to the profession. These tools include such things as a comprehensive history, physical examination, and laboratory tests that registrants are authorized to perform.

**The Chair:** One minute.

**Ms. Moore:** The diagnosis that's arrived at would not differ from a "medical diagnosis," for example, in the case of an acute ear infection. We're concerned that the current wording in Bill 171 will be interpreted as prohibiting NDs from communicating a diagnosis.

Mr. Chair, I'm sorry that I've taken up so much time. I had hoped to leave more for questions and comments. I'll stop here so there's at least a little bit of time.

**The Chair:** Okay, 20 seconds per caucus for questions.

**Mr. Fonseca:** I'd just like to thank the Board of Directors of Drugless Therapy-Naturopathy. What I can say on behalf of the government is that many of your concerns are being addressed in motions. In the short time I have, I'll just mention one here: "Bill 171 does not reduce the naturopaths' current scope of practice"—and the ministry will address the issue of including "disease" in diagnosis through a government motion. That will be one, but I have many that will address your concerns.

**The Chair:** Mrs. Witmer?

**Mrs. Witmer:** This is an excellent presentation. Certainly this allows us to move forward and address some of your concerns.

**The Chair:** Ms. Martel?

**Ms. Martel:** With respect to the communication of a naturopathic diagnosis, if you drop the "naturopathic," are you content with what remains?

**Ms. Moore:** Yes.

**Ms. Martel:** Okay. So the issue is making sure "diagnosis" stands alone.

**Ms. Moore:** It's a qualifier.

**Ms. Martel:** Thanks.

**The Chair:** Good. Thank you very much.

#### ONTARIO MEDICAL ASSOCIATION

**The Chair:** The next presentation is from the Ontario Medical Association.

**Dr. David Bach:** Good afternoon, ladies and gentlemen. I'm Dr. David Bach, and I'm pleased to be here



today, undertaking one of my last formal functions as the president of the Ontario Medical Association before our annual general meeting this weekend. I am an academic radiologist and practise at University Hospital, London Health Sciences Centre.

I would like to begin my remarks today by acknowledging all three parties, and Minister Smitherman in particular, for working with the OMA to address some very serious deficiencies in Ontario's medical audit system. I believe that the amendments being made to the Health Insurance Act through schedule G of Bill 171 faithfully implement the substantial amendments recommended by Justice Cory in his 2005 report on medical audit practice in Ontario.

This has been the single biggest issue for the medical profession over the past several years, and I am very pleased to be able to go into my annual meeting on Saturday and report that important progress has been made in this area. Although our membership will be pleased and relieved by this information, they are likely to come away from the meeting this weekend with the message that just as we are emerging from one procedural quagmire, we are faced with another one in the form of the amendments to the procedural code and the quality assurance provisions under the Regulated Health Professions Act as a result of Bill 171. This is a concern for our members.

It appears that the government is being driven by recent very unfortunate high-profile cases to make amendments to our regulatory processes in order to deal with so-called bad apples. The OMA certainly understands the need to deal with problem providers, but we believe that there are already processes in place to do this. If hospital committees or regulatory colleges are not fulfilling their clear responsibilities, we should deal with that issue directly. We do not need new rules that abandon any semblance of fair process for our providers.

There have also been suggestions that more reporting is consistent with patient safety. While improvements in the system may well be the goal, we need to be careful about how we use the "patient safety" terminology, and I'm going to go into that for about 30 seconds.

The patient safety movement is based within the quality improvement framework. Quality improvement has two principal purposes: The first is to raise the standard of care provided by all practitioners. The second is to deal with the shortcomings in the system or with an individual's performance that will help individuals to perform better.

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Patient safety is predicated on the understanding that the majority of bad things that happen to patients are not due to bad providers. Rather, they are due to the fact that the delivery of health care today is highly complex, with a great number of variables that affect health care outcomes. Patient safety seeks to move away from the "name, blame and shame" approach to one where problems are openly and critically reviewed in a safe environment so that we can learn what went wrong and, hopefully, how to prevent a similar event in the future.

The airline industry has been a real leader in this field. It has redesigned its entire approach to safety to incorporate a sense of shared responsibility for safety, coupled with a rigorous yet confidential review of all incidents and a commitment to systemic change in response to incident analysis. I believe we would do well to follow its lead.

It is important to know that the patient safety approach does not ignore the fact that some actions, generally known as acts of moral turpitude, do require a punitive approach. The key is to be very clear about the boundaries.

Our regulatory colleges have their roots in the punitive model, and it is only over the course of the past decade that they have acknowledged that the vast majority of provider problems can and should be handled within the quality assurance context. The fact remains, however, that colleges have had some difficulty with the transition, in part because their members do not truly believe the colleges have embraced the quality assurance philosophy and partly because the colleges are still charged, at the end of the day, with meting out punishment to members who have transgressed.

Bill 171 will only exacerbate this confusion. Between the many amendments that undermine due process, the rush for disclosure at the expense of undue prejudice and the blending together of disciplinary and quality assurance functions, it is difficult to see how I can assure my members that self-regulation continues to be a fair and useful process or that Ontario remains an attractive jurisdiction for physician recruitment and retention.

Although the OMA is concerned about all of the procedural issues raised by Bill 171, the loss of an independent quality assurance function is of particular concern. Perhaps I might spend a moment and read to you an excerpt from the 2006 advice to the minister by his advisory council, HPRAC:

"For professionals involved in college quality improvement processes, whether peer practice assessments or continuing education, the culture surrounding their participation is vital. They must have the confidence that when changes are identified as necessary in their own practice, or in the practice of a health care team of which they are a part, there is no link to the discipline process. Rather, the link is to enhanced competence, continuing improvement and outcome evaluation. Not only are there benefits to the individual and the health care team, but new aggregated knowledge can be shared with other members of the profession.

"For this reason, HPRAC is recommending that the quality improvement and quality assurance role in colleges be distinct and separate from the discipline process."

It is difficult for me, as a physician, to reconcile this very good advice with some parts of Bill 171, which gives the QA committee the authority to direct the registrar to impose particular sanctions upon a member, and also gives the new inquiries, complaints and reports committee the authority to directly exercise the powers of the QA committee.

I appreciate that schedule M is difficult to follow because of the complexity of the legal issues and I ask you, as a committee, to consider seeking an outside legal opinion from a trusted source, perhaps from the judiciary, to guide you with respect to how the law undertakes the delicate balancing act between justice and fairness in other realms.

I will close by returning to the medical audit situation. The government has recognized that introducing a fair audit process in no way suggests they take a lax approach to billing improprieties. I ask you to bring that same logic to bear here and recognize that fair process in no way implies support for practitioner malfeasance. I ask you to further recognize that quality assurance and dealing with bad apples are two very different processes and need to be kept separate.

Thank you for your attention, ladies and gentlemen. The OMA submission on Bill 171 has been provided to the clerk. I hope you will consider our recommendations in the context of my comments today.

**The Chair:** Thank you. Your timing was perfect. Unfortunately, no questions, though.

#### COUNCIL OF ONTARIO MEDICAL OFFICERS OF HEALTH

**The Chair:** The next presentation is by the Council of Ontario Medical Officers of Health.

**Dr. Graham Pollett:** My name is Graham Pollett. I'm the chair of the Council of Ontario Medical Officers of Health and medical officer of health with the Middlesex-London Health Unit. With me today is Howard Shapiro, associate medical officer of health with the Toronto public health department. We're here today representing medical officers of health and associate medical officers of health in local health units across Ontario.

The shortage of qualified public health physicians is impeding the proper functioning of the public health system at the local and provincial levels. Since SARS, the situation has become worse rather than better. We believe that Bill 171, as now presented, has the potential to add to these problems. Allow me to explain.

The Council of Ontario Medical Officers of Health strongly supports the creation of the Ontario Agency for Health Protection and Promotion, as described in Bill 171. It will provide scientific leadership for public health in this province. It will help recruitment and retention of public health physicians, in the long term, by providing educational support, technical assistance for difficult issues or cases and a new, highly desirable career opportunity.

Unfortunately, in the short term, the agency threatens to make a critical physician shortage worse, as people will most likely leave their current positions for opportunities at the agency.

I will provide a picture of the current shortage of public health physicians through examples from the areas represented by the members of this committee.

Mr. Fonseca's and Dr. Kular's ridings are located in the region served by the Peel health department, the province's second-most-populous health unit. It has taken that health unit over two years to successfully recruit a medical officer of health, due to the lack of interested and properly qualified people. During that time, the medical officer of health position was covered by a physician three years out of the specialty training program and later by a physician who was present on a half-time basis. Currently, there is also a vacant associate medical officer of health position at Peel.

Mr. O'Toole's riding is located in the area served by the Durham region health department. Two associate medical officer of health positions have been vacant for close to a year, leaving a single physician, the medical officer of health, to provide medical coverage for this large health unit.

Mr. Ramal's riding is located in the area served by the Middlesex-London Health Unit, the health unit that employs me.

The associate medical officer of health was called away from her health unit by the chief medical officer of health. This was to provide much-needed medical expertise during a rubella outbreak in Oxford county, where there was no full-time medical officer of health. Currently, there is still no full-time medical officer of health for Oxford county.

Recently, the Middlesex-London medical officer of health and associate have agreed to cover the Perth District Health Unit while it recruits for a full-time medical officer of health.

Also, the physician director of the Middlesex-London Health Unit travel clinic is currently serving as acting medical officer of health for the Chatham-Kent Health Unit. Chatham-Kent has been without a full-time medical officer of health for over two years.

Mr. Mauro's riding is served by two health units: Northwestern and Thunder Bay. In the Northwestern Health Unit, Dr. Sarsfield has announced his plans to retire as medical officer of health at the end of this year. The Thunder Bay District Health Unit recently underwent a one-year process to hire a new medical officer of health.

Mr. Leal's riding is in the Peterborough health unit area. Until new legislation was passed eliminating the mandatory age of retirement, special permission was required from the Minister of Health and Long-Term Care for Dr. Humphreys to continue as medical officer of health. Despite Dr. Humphreys's willingness to continue working, we think this would not have been necessary if there was a strong pool of people available to apply for the position.

The final report of the provincial government's capacity review committee highlighted that 29% of the current complement of medical officers of health and associates plan to retire within the next five years. Who will fill these positions?

The effects of this shortage of public health physicians are not limited to local public health units.



The public health division at the Ministry of Health and Long-Term Care is also having challenges hiring qualified people. A review of the public salary disclosure list shows that the number of full-time physicians on staff at the public health division has gone from six in 2003 to three in 2006. To the best of our knowledge, all three of those physicians listed as working for the public health division are currently on medical leave, and there are a further nine physician vacancies at the public health division. In fact, there are so few qualified physicians at the public health division that the chief medical officer of health position was recently covered for approximately three weeks by a physician with no public health experience.

1700

Why, then, is the Council of Ontario Medical Officers of Health speaking to this committee about what largely appears to be a human resources issue? We are here today because the proposed amendments to the Health Protection and Promotion Act through Bill 171 have failed to address this critical shortage of public health physicians.

In the past five years, this province has produced two valuable reports which speak directly to this situation. The very first recommendation by Justice O'Connor in the Walkerton report reads: "The Health Protection and Promotion Act should be amended to require boards of health and the Minister of Health, acting in concert, to expeditiously fill any vacant medical officer of health position with a full-time medical officer of health."

This recommendation was made in 2002, yet today, nearly a third of the 36 health units in Ontario do not have a full-time medical officer of health appointed by the minister. Something needs to be done to ensure that the Legislature is informed of the progress on this issue and that the chief medical officer of health is empowered to deal with this issue.

To that end, we recommend the following: (1) that the Health Protection and Promotion Act be amended so that the chief medical officer of health is required to report to the Legislature as part of his or her annual report on vacancies for medical and associate medical officers of health, physician vacancies in the public health division and measures taken to address these vacancies; (2) that the Health Protection and Promotion Act be amended to require, where a board of health has failed to duly appoint a medical officer of health, that the chief medical officer of health appoint an assessor to provide a report on the reasons for this and recommended actions to be undertaken to remedy the situation.

The shortage of physicians entering public health as a specialty will not be addressed if medical students do not see the role of medical officer of health as desirable. Strengthening the functions of this role, as recommended by the late Justice Campbell, would help attract new candidates to the field.

To this end, we recommend that the Health Protection and Promotion Act be amended, as suggested by the late Justice Campbell, such that: (1) the local medical officer

of health has full chief executive officer authority for local public health services and is accountable to the local board of health; and (2) the local medical officer of health has independence matching that of the chief medical officer of health to speak out and to manage local infectious outbreaks.

In the words of the late Justice Campbell, "Local medical officers of health and public health units, the backbone of Ontario public health, require in any reform process a strong focus of attention, support, consultation and resources."

"The Ontario government has a clear choice. If it has the necessary political will, it can make the financial investment and the long-term commitment to reform that is required to bring our public health protection against infectious disease up to a reasonable standard."

We strongly urge that this committee recommend to the Legislature the four amendments we have identified in this presentation. We believe this will demonstrate, through action, the commitment of the provincial government to strengthen public health in Ontario.

**The Chair:** There are only about 15 seconds left, so there will be no questions. Thank you very much.

#### COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

**The Chair:** The next presentation is the College of Physicians and Surgeons of Ontario. You have 10 minutes.

**Dr. Rocco Gerace:** Thank you very much. My name is Rocco Gerace. I'm a physician and the registrar of the college. With me is Lisa Brownstone, who is director of legal services at the college.

I would like to thank you for the opportunity of being here today and tell you that we are very supportive of this legislation and that it will go a lot further than the existing legislation in allowing the profession to regulate itself in the public interest. Notwithstanding the improvements, we think that there are changes which would be preferable. While we've circulated a submission, I would like to highlight a few of these.

Firstly, we think it would be advantageous for the legislation to allow a legal chair, a jurist or a senior legal counsel, to chair discipline panels. Increasingly, discipline hearings are becoming complex and litigious, and rather than having professional members and public members deciding legal issues, they should decide the facts at hand. We think a jurist would go a long way to expediting these procedurally demanding hearings.

Secondly, we think that, in very selected circumstances, search warrants should allow entry into the dwellings of the member. Occasionally, doctors maintain critical information in their homes and successful prosecution of serious cases is dependent on this information. More recently, we had an issue with a doctor providing cosmetic surgery against a condition that had been imposed and in fact harming patients. It was only because we were able to garner the records from his home that we were able to prosecute.

Thirdly, while the legislation demands that doctors be notified of a complaint within 14 days, and we agree with this for the most part, there are rarely circumstances where, in the interest of preserving evidence, longer time is needed. We would ask that consideration be given to changing that for exceptional circumstances.

Finally, I'd like to address the issue of transparency. We are concerned that this legislation actually decreases the amount of transparency available to the regulatory body. Currently, severe findings are put on the public register on our website indefinitely. This legislation would allow this information to be removed from the website after a period of six years with application. We think this is regressive, and we think the profession should have the opportunity to be sufficiently transparent to ensure that there's public trust in the system.

There's a total of 14 recommendations in our submission. I won't go over them all, but I would be happy to answer any questions that anyone might have.

**The Chair:** Thank you. We have quite a bit of time for questions, so we will start with Ms. Witmer.

**Mrs. Witmer:** I'd like to focus on recommendation 2, the search warrants. Do you want to just speak to that issue?

**Dr. Gerace:** Sure. Currently, when a search warrant is obtained, the investigators have the right to enter a doctor's premises. With the change in the legislation, this would be precluded. Very rarely doctors will keep critical information within their residence that is crucial to the investigation and ultimately to a prosecution. So we think there should be an allowance with respect to that to allow investigators, with appropriate protection, to be able to go into a physician's residence.

**Mrs. Witmer:** Would you just expand on the disclosure of member information of a serious nature after the six years?

**Dr. Gerace:** Of course. Currently, with the combination of statute and bylaw, all serious matters, serious findings from a discipline panel remain on the public register indefinitely, so the public will always have access to that information. With the revisions to the legislation, the member will have the ability to apply to have that information removed at the six-year mark. We continue to believe that that information should be public and stay public indefinitely.

**Mrs. Witmer:** Forever?

**Dr. Gerace:** Yes.

**Mrs. Witmer:** To better protect the public?

**Dr. Gerace:** The public will be aware of serious findings.

**Mrs. Witmer:** What about that provision for separate pre-hearing panels?

**Dr. Gerace:** As you may know, we currently have difficulty given the requirement in respect to the composition of panels for the discipline committee. If we have multiple panels to consider motions before the hearing actually begins, there's the potential for actually exhausting the number of panel members we have available to sit. It's not the case now. We've not encountered any

difficulty, and so we feel that that provision is unnecessary.

**Mrs. Witmer:** Thank you very much.

**The Chair:** We need to move on to Ms. Martel.

**Ms. Martel:** Thank you for being here. Actually, some of your concerns were echoed yesterday by the registrar for the Royal College of Dental Surgeons of Ontario. I just want to focus on a couple around the search warrant. I've looked at this a couple of times, and I can read it both ways. So I really do suggest the government change the wording on this one—because as it stands, it is confusing about what the intent is. I'm hoping the intent is to include a house, because that would have followed from what we did on Bill 140, but it needs to be cleaned up in its current composition.

1710

I guess what I want to focus on, and I don't mean to put you on the spot, but I'd be interested on your views—you might have heard the presentation done by the OMA. I want to ask about quality assurance and the changes that are being proposed by the government around the QA committee directing the registrar to impose sanctions. The second concern raised was that this would give the new inquiries, complaints and reports committee the authority to exercise the powers of the quality assurance committee.

As the registrar for the college that will have to deal with this, what are your views about the proposed changes in that area?

**Dr. Gerace:** I think the changes are fine. It's interesting that the greatest criticisms we get from the profession are not having taken adequate steps to protect the public. What can happen in the quality assurance stream is that a doctor could be entirely uncooperative through the process. Keep in mind that the vast majority of doctors want to practise well. When the deficiencies are identified, they are very keen to become educated, and do so. Within the quality assurance stream currently, there is a provision for a suspension if the doctor fails to co-operate, and really this puts into statute what already exists in regulation.

In respect to the investigative stream, I think that's intended when there are issues around education. If there is a course that would be helpful for the physician, rather than go to a full disciplinary hearing, it will allow the committee to ask the doctor to take that course. I think Lisa might want to comment. The doctor always has the right to take that decision to divisional court if they're concerned about its propriety.

**The Chair:** We need to move on. I'm sorry. Mr. Fonseca.

**Mr. Fonseca:** I'd like to thank the College of Physicians and Surgeons of Ontario for your presentation. I'm glad that your representatives are meeting with the ministry. We are going to be addressing two of your concerns that you've brought forward. The search warrant and dwellings issue will be addressed in a motion, and the six-year application period to re-register is being addressed through a motion.



I want to ask a question around transparency. This legislation is about better protection for patients. The bill is going to enhance all regulatory colleges—their complaints procedures—by giving patients increased access to information and improved communications, and streamline that process.

I know that this has been somewhat contentious in terms of what access patients should have and how quickly they should have it. Can you give me your thoughts on that?

**Dr. Gerace:** Our main concern in respect to the legislation was that this information would be removed, and I'm pleased to hear that that information will stay on the register and changes will be made in respect to that.

Other information, I think, requires discussion. There should be adequate information on the public register to assure the public that regulation is occurring appropriately. We have to ensure public trust.

If there are other suggestions around what might additionally be on that register, I think we should talk about it. The concern, always, is the unintended consequences of including too much information. And so, if there is a plan to include more information, I would urge that there be an open debate around the proposed information to be included, to have that assurance.

**Mr. Fonseca:** Do you have a suggestion in terms of what information?

**Dr. Gerace:** No. We haven't really addressed that in this submission.

**The Chair:** We're out of time. I'm sorry. Thank you.

**Dr. Gerace:** Thank you.

#### ONTARIO COALITION OF MENTAL HEALTH PROFESSIONALS

**The Chair:** The next presentation is the Ontario Coalition of Mental Health Professionals. Welcome.

**Ms. Naseema Siddiqui:** Good afternoon, Mr. Chairman and members of the committee. My name is Naseema Siddiqui, and I am the chair of the Ontario Coalition of Mental Health Professionals. The coalition is made up of voluntary associations that represent approximately 4,300 members. These are unregulated practitioners in the province. The coalition has been advocating the statutory regulation of mental health professionals for many years.

We welcome the introduction by this government of the Psychotherapy Act, 2006. We participated in the consultation initiated by HPRAC and Minister Smitherman that led up to the introduction of the act. The coalition believes that the act reflects the key public policy issues of protection of the public, choice of practitioners and access to services, and diversity, which are the cornerstones of the RHPA.

I will now ask Kevin Stafford, chair of the coalition's advocacy committee, to comment on the Psychotherapy Act, 2006, on behalf of the coalition.

**Mr. Kevin VanDerZwet Stafford:** Thanks, Naseema. I'm Kevin VanDerZwet Stafford. I'm chair of the advoca-

cacy committee. I'm a marriage and family therapist in private practice in Guelph. I'm very pleased to address this committee on the Psychotherapy Act on behalf of the Ontario Coalition of Mental Health Professionals.

I'd actually hoped that my husband, Bryan, and our two children would have been here to pay witness to these hearings today. However, you'll understand that through the eyes of a seven-year-old, swimming lessons were of far greater interest than these committee hearings.

**The Chair:** They are to us, too.

**Mr. VanDerZwet Stafford:** Maybe we should all go swimming.

Many members of the public mistakenly believe that regulation is already in effect and are unaware that they are being treated by practitioners who are not legally accountable. Anyone can hang out a shingle in Ontario saying that they provide mental health services and answer to no one about their training and competence to practise.

The coalition of mental health professionals welcomes the Psychotherapy Act as a long-overdue answer to the vast pool of unregulated practitioners who are currently not accountable for the mental health services they provide to an unsuspecting public.

The coalition supports the Psychotherapy Act because it meets key public policy objectives that underlie the Regulated Health Professions Act. Among these are:

**Public protection:** The Psychotherapy Act provides legal accountability for the thousands of practitioners delivering psychotherapy services, with entry-to-practice standards, continuing education, complaints and disciplinary procedures.

**Choice and access to service:** The new College of Psychotherapists will capture a broad range of professionals practising as counsellors, counselling therapists, psychotherapists, marriage and family therapists, etc., thereby ensuring that the public continues to have a choice of qualified practitioners and access to much-needed services.

Finally, and significantly important, I believe, is diversity. The multidisciplinary nature of the new college will ensure that diverse communities can access services that are culturally competent and culturally relevant.

One small example would be my own marriage and family therapy practice in Guelph, which caters largely but not exclusively to the gay-lesbian-transgendered community.

I'd like now to address specialty subtitles. It is in the very nature of mental health services to be inclusive of a broad range of practitioners who are specialized in areas of practice, such as marriage and family therapy, pastoral counselling, art therapy, addiction therapy, etc. Establishing specialty subtitles in or under the act would give the public an additional tool in accessing the most appropriate practitioners to meet their mental health needs in a time of crisis.

The coalition was very disappointed that there was no provision in the Psychotherapy Act for specialty titles



under the two protected titles of “psychotherapist” and “registered mental health therapist.” As a result, we are proposing an amendment to section 8 of schedule Q to add subsection (4) to read, “Specialty subtitles shall be designated under the protected titles of ‘psychotherapist’ and ‘registered mental health therapist.’”

Some stakeholders are calling for the involvement of professionals already regulated under the Regulated Health Professions Act in setting up the new regulatory regime under the Psychotherapy Act. Let me be clear. The coalition feels very strongly that there is the necessary expertise, both clinical and academic, in the currently unregulated sector to meet the challenge of setting standards for entry to practice and dealing with all the attendant policy issues.

One such issue is: Who should be authorized to perform the authorized act? As an example of the expertise in the unregulated sector, Beth Symes, the coalition counsel, has already conducted initial research comparing Alberta and Ontario, as cited in our brief. The coalition recommends strongly that a critical mass of appointees to the transitional council be drawn from the unregulated sector.

1720

In conclusion, I would like, on behalf of the coalition and Naseema, our chair, to thank the committee for the opportunity to express our very strong support for swift passage of the Psychotherapy Act in the current session.

**The Chair:** Thank you. Fifty-five seconds per caucus, starting with Ms. Martel.

**Ms. Martel:** Thank you for being here today. The amendment around section 8 I am pleased to see because the question was, who is a registered mental health therapist, right? We need some other subcategories to ensure that we are really including all of those who are unregistered, and I trust that the new college will have the capability of determining the educational requirements associated with those categories.

Just briefly, because I’m trying to compare very quickly: The authorized act that you set down on page 6—is there a difference between that and the one that is currently in the act? I’m trying to read quickly, but I didn’t get there fast enough. Is there a change or are you endorsing the authorized act that appears right now in Bill 171?

**Mr. VanDerZwet Stafford:** We’re endorsing it.

**Ms. Martel:** So it’s the one that’s there now. Okay. Thank you.

**The Chair:** Mr. Fonseca?

**Mr. Fonseca:** I’d like to thank the coalition for your fine presentation and I’d like to address your concerns.

Within the RHPA proper, it does allow the council to make regulations, and I’ll just read from regulation 95(e), which is already in the RHPA, as I said: “defining specialties in the profession, providing for certificates relating to those specialties, the qualifications for and suspension and revocation of those certificates and governing the use of prescribed terms, titles or designations by members indicating a specialization in the pro-

fession.” So it is allowed. You will be able to have your different designations, be it marriage and family therapy or social worker or whatever it may be within mental health professionals.

As we build what is deemed our HealthForce Ontario, we want to make sure that everybody is included and that the public is well aware of the professionals they are seeking out for the therapy they need. Thank you.

**The Chair:** Ms. Witmer?

**Mrs. Witmer:** Thank you very much. Your members have done a good job of letting us know your concerns and the need for swift passage. We appreciate this information. It will be very helpful.

**The Chair:** Thank you for being with us.

## ONTARIO PUBLIC SERVICE EMPLOYEES UNION

**The Chair:** The next presentation is the Ontario Public Service Employees Union. I would ask if you would state your name for Hansard.

**Mr. Smokey Thomas:** Smokey Thomas.

**Ms. Patty Rout:** Patty Rout.

**The Chair:** And congratulations on your recent election. You have big shoes to fill.

**Mr. Thomas:** Thanks, Ernie. I appreciate that.

Good afternoon. My name is Smokey Thomas, and I am the newly elected president of OPSEU. With me is Patty Rout—Patty is our newly elected first vice-president and treasurer—and Patrick Fry-Smith. Patrick is from ambulance dispatch.

It is appropriate that we meet here today during National Medical Laboratory Week, and we would draw your attention to the fact that 85% of decisions about diagnosis and treatment are based on laboratory results.

Thank you very much for this opportunity to speak about this bill, which is of great importance to many of our 125,000 members, not just those in health care.

OPSEU’s concerns around Bill 171 fall into four areas: One is the accountability of the new Ontario Agency for Health Protection and Promotion. Two is the plan to transfer about 600 workers from the provincial public health laboratories out of the Ontario public service and into the new agency. Three is the omission of a strong worker safety role for the new agency. Fourthly is the broad definition of “psychotherapy” and its sweeping implications for many public sector professions.

OPSEU continues to call on the government to rebuild Ontario’s public services and repair the damage caused by more than a decade of cuts to funding, staff and services. Nowhere has this damage been more evident than in Ontario’s public health protection system—from the Walkerton tragedy in 2000, through the 2003 SARS crisis, to the Toronto legionnaires’ outbreak in 2005. Each of these events revealed significant flaws in our health protection and surveillance systems, flaws that resulted directly from conscious policy decisions by government, ongoing underfunding and chronic neglect.



OPSEU actively contributed to both the O'Connor commission's Walkerton inquiry and Justice Campbell's SARS commission, and we have endorsed many of their key recommendations. This includes the call by both commissions to create a new Ontario Agency for Health Protection and Promotion as an agency of the Ministry of Health and Long-Term Care under the operational authority of the chief medical officer of health and the direction of a competent board appointed by the Minister of Health, and to transfer the Ontario public health laboratories to this new agency.

However, we have a number of very serious concerns about this act and its ability to achieve these objectives.

We note that the proposed agency will operate at a very long arm's length from both the Minister of Health and Long-Term Care and the chief medical officer of health. The chief medical officer of health will be neither a member of the new agency's board nor on its senior management team. The CMOH will also have authority to direct the agency's activity only in emergency and outbreak situations.

This runs directly contrary to Justice Campbell's recommendation that the CMOH have a hands-on role at the agency, including a seat on the board. Indeed, as he noted in his final report, the model put forward in this bill represents a completely opposite approach and ignores important lessons from SARS.

By establishing the new agency outside of the Ontario public service, the bill will undercut both the agency's accountability to the minister and the minister's direct accountability to the public for the agency's operations. It will reduce the transparency of the agency's operations while making it much more difficult to improve coordination between the public health labs, the ministry's public health branch and the rest of the health care system. It will do nothing to ensure that the new agency receives adequate funding from the ministry to reverse past cuts and to meet the public health challenge of the future. Finally, it will create unnecessary uncertainty and dislocation for the almost 600 OPSEU members who work in the provincial public health labs and will increase the risk of service disruptions and other problems during this important transition.

Justice Campbell recommended the establishment of whistleblower protection for health care workers to ensure prompt reporting of public health risks to the authorities. The government has yet to take action on this.

Under recent changes to the Public Service Act, Ontario public service employees, including employees at the provincial public health laboratories, will soon have whistleblower protections—protections which they will lose if the new agency is established outside the OPS.

OPSEU therefore recommends that the act be amended to establish the new agency within the Ontario public service and under the authority of the chief medical officer of health in his or her capacity as an assistant deputy minister within the Ministry of Health and Long-

term Care. This would allow the government to ensure the necessary independence and expertise of the new agency's board and senior management while preserving direct accountability to the minister and the public for its operations.

I would now like to hand it over to Patty to finish up.

**Ms. Rout:** Worker safety: Although not a formal recommendation, it is noteworthy that Justice Campbell amended the name of the new agency—Ontario Agency for Health Protection and Promotion and Worker Safety—in the section devoted to recommendations regarding the agency.

OPSEU strongly endorses the following recommendations which were made by Justice Campbell:

- that the Ontario Agency for Health Protection and Promotion should have a well-resourced, integrated section that is focused on worker safety research and investigation and on integrating worker safety and infection control;

- that any section of the Ontario Agency for Health Protection and Promotion involved in worker safety have, as integral members, experts in occupational medicine and occupational hygiene and representatives of the Ministry of Labour, and consult on an ongoing basis with the workplace parties;

- that the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety;

- that the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety;

- that the Ontario Agency for Health Protection and Promotion ensure that it become a centre of excellence for both infection control and occupational health and safety; and

- finally, that the mandate of the Ontario Agency for Health Protection and Promotion includes research related to evaluating the modes of transmission of febrile respiratory illnesses and the risk to health workers. This research should also identify the hierarchy of control measures required to protect the health and safety of workers caring for patients with the respiratory illnesses.

1730

Justice Campbell describes how the two solitudes of infection control and worker safety contributed to the spread of SARS and the chaos created in Ontario's health system and beyond.

OPSEU believes that it is critical to broaden the mandate of the proposed new agency, as a necessary first step to demonstrate the importance of worker safety and to make the critical links between worker safety and the safety of the public. It is a grave error to try to separate the health and safety of patients and the public from the health and safety of workers.

These changes would help ensure that the new agency's structure and mandate are more consistent with Justice Campbell's recommendations—

**The Chair:** One minute.

**Ms. Rout:** Okay.

In the meantime, if a new agency is established outside of the Ontario public service, we want to know:

- that successor rights will apply to all OPSEU members;

- that participation in the OPSEU pension plan will be grandfathered;

- that no OPSEU member will be laid off; and

- that no services will be privatized, downloaded or contracted out.

You have the rest of the presentation before you. Thank you.

**The Chair:** Thank you. We appreciate the presentation, and it certainly will be read.

#### ONTARIO KINESIOLOGY ASSOCIATION

**The Chair:** The next presentation is by the Ontario Kinesiology Association. I hope I'm close.

**Ms. Conny Glenn:** Close.

**The Chair:** I am an engineer; I'm trained, not educated.

**Ms. Glenn:** We share a kinship, then.

**Mr. Jeff Leal (Peterborough):** And a great engineer, too.

**The Chair:** Well, thank you. Hansard, please note that Mr. Leal said I'm a great engineer; I may need that as a job reference after October.

You have 10 minutes. Please state your names for Hansard first.

**Ms. Angela Pereira:** Thank you very much for the opportunity to present to you this afternoon. My name is Angela Pereira. I'm the current president of the Ontario Kinesiology Association. Our membership thanks you very much, as well, for the opportunity of presenting to you today.

I'll tell you a little bit about the background of the Ontario Kinesiology Association to give you a little bit of reference.

First of all, the OKA has been the representative body for the profession of kinesiology for 25 years in Ontario. We're currently comprised of two branches: the Ontario Kinesiology Authority, which manages certification and handles quality-of-service issues; and the Ontario Kinesiology Society, which provides membership services and promotes the profession.

To become a certified member, you must obtain a minimum of a four-year bachelor of science degree in kinesiology, with core competencies in anatomy, physiology, biomechanics, motor control and learning.

There are currently 13 universities in Ontario that offer kinesiology degrees.

Our current membership of 1,500 is primarily female, which comprises about 72%, and the vast majority are 26 to 30 years of age—41.5%. A full one third work in private rehabilitation clinics, with almost another one third working with employers providing ergonomics, health and safety, return-to-work, and wellness services. The remainder work in the health care system, in insur-

ance sectors, and also as physical fitness or activity consultants.

At this point, I'd like to introduce you to Conny Glenn, our executive director, who will talk to you a little bit further about what the regulation means to us.

**Ms. Glenn:** Thank you very much for allowing us to come and present today.

As Angela mentioned, I'm the executive director for the Ontario Kinesiology Association. I was formerly the president for a couple of years, as the initiative toward regulation began. I do work in private practice, as well, as an ergonomist.

I'd like to begin by thanking the Minister of Health and Long-Term Care, the Honourable George Smitherman, for moving forward with this legislation. We feel that it's long overdue to have a look at the regulation of kinesiology.

I'd also like to thank HPRAC, the Health Professions Regulatory Advisory Council, for their hard work during this process. We spent the last couple of years working with them. We felt that the process was very fair, very thorough, and they did an excellent job. So we commend them for that.

We'd like to unequivocally state that we are in full support of Bill 171 and that we are in full support of regulation for kinesiology and the other professions. Regulation, of course, exists to protect the public, and we believe it's imperative that the public be afforded that protection when they seek out the services of kinesiologists. That's why we would like to see this bill continue to progress forward. We see this as the next logical step in the evolution of the profession of kinesiology, and we see that as being in keeping with the evolution of health care here in Ontario.

Health care truly seems to be moving from a sick-and-illness model toward a health-and-wellness model, and that's one that we fit in very well with. I don't think I need to explain to the members here today the epidemics we're facing, the alarming rates of obesity, diabetes, cardiovascular disease and certainly the musculoskeletal disorders that are threatening the very economic stability of a lot of businesses. Currently, musculoskeletal disorders affect several hundred thousand people on a regular basis, and what we're seeing is a huge cost to businesses in terms of having to deal with and manage this.

Just a couple of quick stats to bring you up to speed in case you're unfamiliar: The estimated costs for cardiovascular disease in Canada were approximately \$19 billion, and it's still the leading cause of death—very alarming, given that it's highly preventable. I think that's the common theme we see with the disorders that I'm discussing with you today, that they are manageable, they are treatable and they are preventable. The very services that kinesiologists provide allow for the costs to be reduced. We would like to urge you to move forward with the bill because we feel it's in the best interests of the public to regulate kinesiology and allow the public further access to kinesiology services.



We are experts in human movement and exercise. Once regulated, the public will be allowed the protection and the comfort of knowing that the providers of kinesiology services are well qualified, that they're accountable for their actions. We're ready to step up to that challenge and to be accountable for what we do on a regular basis.

We'd like to sum up here today that we feel this is a very valuable and important piece of legislation that should move forward. It protects the interests of the public by protecting them, allowing them an access and a mechanism to challenge and question what kinesiologists do. It protects the integrity of the profession, and that's paramount in importance to us, that we're seen as being a consistent profession, that it's clearly understood what we do and how we offer that to the public. Last but certainly not least, it impacts on the economy of Ontario. These diseases and conditions that I've mentioned are running rampant. They are costing not only the health care system but the economy of Ontario. We see headlines on a regular basis that are pointing this out. I bring to your attention today's business section of the Toronto Star and yet another headline, "Obesity Eats into Bottom Line, Study Warns"—just another example of exactly the sort of thing that I'm discussing. So in terms of protecting the economy of Ontario, I think it's imperative that this bill move forward and that we continue to be able to offer those services with a high level of accountability to the province of Ontario.

**The Chair:** Are you finished?

**Ms. Glenn:** Yes.

**The Chair:** We have not quite a minute for each caucus. We'll start with Mr. Fonseca.

**Mr. Fonseca:** I'd like to thank the Ontario Kinesiology Association for your fine presentation. We often find that many presenters have come and said, "We've waited so long, and we're so happy that you are in sync with what we're doing." Actually, we are catching up to many of you in terms of being able to provide alternative health care services.

Can you tell me the impact this legislation will have on your profession? You've mentioned assurances for the public. Will you see an increase in numbers? We formed the Ministry of Health Promotion a year and a half ago in the government of Ontario. We want to move with you. We'd like to know how this will help you.

1740

**Ms. Glenn:** I think we can address that very easily. I think we're going to see more kinesiologists getting into health care. As we mentioned, there are 13 universities here in Ontario that graduate kinesiologists, and one of the things we're seeing is that they're devising specialized streams. For example, the University of Ottawa is at this moment putting together a stream that would specialize kinesiologists in physical activity counselling; we know that that's certainly an area where we're well needed. We're seeing kinesiologists begin work with family health care teams in that very role. So I think you're going to also see that kinesiologists, by virtue of

the fact that there are a number of extremely strong programs here in the province, are going to be able to unburden some of the health care providers in other areas. For example, we have kinesiologists right now who work providing case management services; we know there are also nurses who do that, and we certainly value the service they provide there, but there's a shortage of nurses in this province. So we are a bright, young pool of people—

**The Chair:** I need to move on. Mrs. Witmer.

**Mrs. Witmer:** I'll be very brief. We're thrilled that there's going to be the new college established. There's definitely a need in the province for the services you provide. I wish you all the best. We certainly would never hold up this part of the bill.

**Ms. Martel:** Can you describe to the committee the association's governance and quality assurance branch—because that's established now through the association, not through a college.

**Ms. Elyse Sunshine:** My name is Elyse Sunshine. I'm counsel to the association.

Recognizing that this was, in essence, a self-governing profession without the legislative teeth, we modelled ourselves after the RHPA and separated, under one roof, the association, which is the promotional body, from the regulatory body, the authority. We kept as close as humanly possible to the RHPA in the hopes that ultimately we would find ourselves where we are today and be able to divide off the regulatory branch from the promotional body. So—

**The Chair:** Thank you. My life is governed by this. I'm sorry. We're out of time.

#### ONTARIO COLLEGE OF SOCIAL WORKERS AND SOCIAL SERVICE WORKERS

**The Chair:** The next presentation is the Ontario College of Social Workers and Social Service Workers. Welcome. Please state your names for Hansard. You have 10 minutes.

**Dr. Rachel Birnbaum:** My name is Rachel Birnbaum. I have the privilege of being the president of the Ontario College of Social Workers and Social Service Workers. With me is the registrar of the college, Glenda McDonald, and legal counsel for the college, Debbie Tarshis.

I wish to thank the members of the committee for agreeing to hear our presentation this afternoon.

The college is the regulatory body for social workers and social service workers in Ontario, with approximately 11,500 members. The college is seeking amendments to Bill 171 to ensure that the bill recognizes the key role played by almost 7,000 social work members currently working in settings delivering psychotherapy services and enables them to continue playing that role by being included in the proposed legislative framework of Bill 171.

As you know, no one disputes that social workers have the skill, judgment and qualifications to provide psychotherapy services. The college is pleased that Minister Smitherman has made a commitment to present a legislative amendment that will recognize the profession of social work and to ensure that social workers who provide psychotherapy services associated with the new controlled act will continue to be able to provide these important services in the province of Ontario. The college wants to ensure that we are able to regulate our members effectively and in the public interest with respect to the provision of psychotherapy services.

In the interests of time, the following are the key amendments to Bill 171 being sought by the college. Other recommendations can be found in our written submission, which I believe you all have.

(1) That schedule Q be amended to provide positive authorization for social workers to perform the controlled act related to psychotherapy.

(2) That schedule Q be amended to permit social workers to use the restricted title "psychotherapist," provided that this title is used in conjunction with the restricted titles "social worker" or "registered social worker."

(3) That schedule Q be amended to exempt social workers from the holding-out provision in the Psychotherapy Act, 2006, provided that they comply with the Social Work and Social Service Work Act, its regulations and bylaws, so that a social worker would be able to represent that he or she is qualified to practise as a psychotherapist in Ontario.

Thank you for the opportunity to make this submission to the standing committee and for your consideration of the college's concerns and recommendations.

**The Chair:** Thank you. We have about a minute and a half or better for questions. We will start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much. As I said to one other group, we've heard from the social workers and maybe that's because we have so many students in our community who are part of the program.

You refer to the doctoral degree and the use of the title "doctor." Do you just want to expand on that as to why you see that being so important and so necessary?

**Dr. Birnbaum:** Yes. As an academic who has earned the degree of a Ph.D., a doctoral degree, I think it is important that we be allowed to call ourselves "doctor." In our submission, you will find our response to that very issue, which supports that we be allowed to call ourselves "doctor."

**Mrs. Witmer:** I certainly do support that.

I guess the other key issue for you was the fact that you were excluded at first—

**Dr. Birnbaum:** Yes.

**Mrs. Witmer:** —from the provision of psychotherapy. But it appears that the government has indicated that they will be introducing amendments to deal with that. Are you pretty confident that the issue is going to be addressed?

**Dr. Birnbaum:** I am not aware of that issue.

**Ms. Glenda McDonald:** We've been assured that there will be an amendment introduced. I think we're still working with—we hope we're working with—the government to ensure that the amendment is consistent with our public policy recommendations on this matter: that there is positive authorization, that social work is treated on an equal footing with the other professions that have been authorized to perform the controlled act. So those are key issues. To our knowledge, it's not there yet.

**Mrs. Witmer:** I guess this is it. At first I had heard that that definitely was there, but now you're expressing some reservation as to what that might look like.

**Ms. McDonald:** That's correct.

**The Chair:** Ms. Martel?

**Ms. Martel:** Thank you for being here today even though we had an earlier presentation by the association, who expressed, of course, similar concerns.

I look at your series of amendments on page 4. They gave us a single amendment. Maybe legal counsel might have a better idea of this. I'm not sure if you've seen what the association has put forward—because I don't want to be in a position of putting forward different amendments. I'm not sure if you're in a position to comment on what they've put forward and whether that addresses the college concerns as well.

**Ms. Debbie Tarshis:** The college would be pleased to carefully consider the language that has been proposed by the association, and it's our intention to do that.

**Ms. Martel:** Have you had a chance to do that yet?

**Ms. Tarshis:** Not a sufficient chance to do that.

**Ms. Martel:** So it would be useful, I suspect, if we have some further conversation so that whatever goes forward reflects the needs and the concerns of both. We'll have to do that outside of this hearing process.

**The Chair:** Mr. Mauro?

**Mr. Bill Mauro (Thunder Bay–Atikokan):** Thank you very much for your presentation and for acknowledging the efforts of Minister Smitherman in this regard, and also for acknowledging that it was never the intention to exclude social workers from the controlled act related to psychotherapy.

In your list of hoped-for amendments, number 3, I'm wondering if you could expand for me a little bit on this "holding out" provision in the Psychotherapy Act, 2006.

**Ms. Tarshis:** Schedule Q sets out a restricted title of "psychotherapist" and "registered mental health therapist," and then there is a restriction that a person not hold themselves out as being qualified as a psychotherapist in Ontario. So the two really go together.

The college is very concerned that there will be confusion among the public as to those qualified professionals who are qualified to provide psychotherapy services, which is the basis for the college's recommendation that social workers be permitted to use the title "psychotherapist." So the two go hand in hand.

**Mr. Mauro:** Understood, then. Thank you for that.

**The Chair:** Thank you. We appreciate your being with us.



We will start the next presentation with one caution: that there may be a vote. So if the bells ring, we will have to recess, and then we will complete after the vote.

### ONTARIO DENTAL HYGIENISTS' ASSOCIATION

**The Chair:** The next presentation is Michelle Clement. Welcome.

**Ms. Michelle Clement:** Thank you. Good afternoon.

**The Chair:** You need to state your name for Hansard.

**Ms. Michelle Clement:** My name is Michelle Clement, and with me today Margaret Carter, who is the executive director of the Ontario Dental Hygienists' Association. I am a registered dental hygienist who has been working in Belleville, Ontario, for the past 18 years.

It is an honour for me to be here today representing a profession that I love, and one that has evolved over the last 50 years from "cleaning ladies" to self-regulated dental health professionals. The process we are involved with here today is an opportunity to continue this evolution and for this government to improve the accessibility and affordability of dental hygiene services for the public of Ontario by the provider of their choice.

1750

In its 1996 report, HPRAC found that the ladder system of education of dental hygiene at the time was basically equivalent to the two-year training programs elsewhere in Canada and the United States. HPRAC was also of the opinion that the same skills and judgement are required to make the decision to proceed or to refer under self-initiation as under a standing order. Therefore, according to the HPRAC recommendation, no changes in the education and training were necessary to carry out the same decision-making process.

Since the 1996 report, dental hygiene has become a direct-entry, two-year program. As self-regulated professionals, we must participate in a quality assurance program. As lifelong learners, dental hygienists set goals for learning and focus on activities that complement their practice setting and enhance their knowledge and skills. Ethical and professional dental hygienists do not act in a manner that would compromise their patients' health, nor do they jeopardize their own ability to earn a living by committing professional misconduct.

HPRAC recommended an amendment to the Dental Hygiene Act to allow dental hygienists to self-initiate, subject to appropriate restrictions in regulations and standards. During the negotiations in 2006, we reiterated the confidence we had in the CDHO, our regulatory college, to do its job in the public's interest. Since the beginning, our college has been committed to appropriate regulations and standards of practice to make self-initiation a reality for our profession.

While there is a definite need and a willingness of dental hygienists to investigate alternative practice settings, dental hygienists have often been stymied by dentistry in denying an order. I believe you heard from a colleague of mine yesterday, Sheryl Sasseville, who

spoke eloquently of the challenges that she faces in providing care in long-term-care homes. For reasons that remain unclear, dentists have been reluctant to enter into professional arrangements with dental hygienists.

Periodontal disease is among the most prevalent chronic diseases affecting children, adolescents, adults and the elderly. Recent research indicates an association between periodontal disease and heart disease, and a probable bidirectional association between diabetes and periodontal disease. Since cardiovascular disease is multifactorial, all known means of prevention should be implemented, including oral hygiene maintenance. The prevalence of diabetes is increasing over time, taking an immense financial toll on Canadians, costing \$9 billion in health care, disability, work loss and premature death. Evidence shows that periodontal therapy, i.e., scaling and root planing, leads to improvement in glucose control. We must take immediate action to give Ontarians access to the preventive services of a dental hygienist. We must make oral health part of overall health for Ontarians.

In October 2005, Minister Smitherman invited the Ontario Dental Hygienists' Association and the Ontario Dental Association to discuss the order issue. At that time, I was the president of the ODHA, and along with my executive colleagues and the help of a negotiator, we worked with the dental association and discussed areas of dental health that both associations could mutually and cohesively work together on. During these discussions, we also attempted to understand each other's position with regards to the order.

I believe we accomplished two things during these negotiations. The ODHA accepted the challenge of negotiating and collaborating with dentistry to resolve a 14-year struggle, and these negotiations proved that both professions—dentistry and dental hygiene—could collaborate and work together in areas of mutual concern.

I would like to share my time with the ODHA and ask Marg Carter to say a few words.

**Ms. Margaret Carter:** Thank you. First and foremost, I would like to say how thrilled we are to be here to speak to Bill 171. It's a momentous occasion for our profession. I would also like to thank Michelle for generously sharing her time with the ODHA, the professional association representing the interests of dental hygienists in Ontario. The ODHA has been speaking on behalf of the profession since it was established in 1963.

Dental hygienists are highly skilled in helping clients to attain and maintain optimum oral health. As members of the oral health care team, they are responsible for professional treatment that helps to prevent gum disease, and they provide a process of care that involves assessing the oral condition, planning treatment according to individual needs, implementing the treatment plan, and evaluating the success of the treatment and planning for the future.

Once the Dental Hygiene Act is amended to remove the order requirement, Ontario consumers will have more affordable and more accessible dental hygiene care. A



conservative estimate of cost savings for ordinary Ontarians is 30%. Allowing dental hygienists to provide care without a dentist's order and to provide these services outside of a dentist's office removes the almost insurmountable obstacle to care for seniors, the uninsured, low-income families, students attending school away from home, those in long-term-care homes, as well as those in rural and remote areas.

Dental hygiene is a mobile profession, and a growing number of dental hygienists are prepared and committed to taking their services to those underserved groups. Passage of Bill 171 will allow the public this oral care service and the right to choose their health care provider.

Dental hygienists have provided care for more than 50 years in Ontario and know when it is safe to provide these services and when to consult with a family physician, nurse practitioner or dentist. There has never been a single complaint related to scaling and root planing against a dental hygienist. The dental hygiene regulatory college has never had to discipline a dental hygienist for an incident caused by improper or inappropriate scaling and root planing.

In 1995, and again in 1996, after extensive review, HPRAC concluded that the order requirement for "teeth cleaning" serves no public policy purpose and should be removed, subject to regulations developed by the dental hygiene regulatory college.

On behalf of the members of the Ontario Dental Hygienists' Association and dental hygienists in Ontario, ODHA would like to thank the government for moving forward with the amendment to the Dental Hygiene Act and, in doing so, fulfilling a promise made to the profession and providing Ontarians with access to much-needed preventive oral health services.

**Ms. Clement:** In my final point, I would like to discuss the concept of inter-professional collaboration among health care professionals. I was privileged to participate in the summit on advancing inter-professional education and practice held last June. Inter-professional care is care provided by a multidisciplinary team of health care professionals who work in synergy and learn from each other in order to provide comprehensive services to patients in various health care settings.

Ladies and gentlemen, I would like to thank Minister Smitherman for the incredible amount of hard work that he put forward into this bill, and I'm asking you to recommend Bill 171 for third reading and the opportunity to move the dental professions forward as role models and, indeed, champions of the change toward inter-professional care.

**The Chair:** Thank you. We have 25 seconds per caucus, starting with Ms. Martel.

**Ms. Martel:** Thank you very much to both of you for being here. Thank you, Michelle, for travelling from Belleville to be here. We did indeed hear from Sheryl yesterday, who comes from my riding—she lives in my riding—and who shared her story with me, her ongoing saga of over two years now. So we appreciate that you're here. That's a long way to come. Thank you very much for making the effort.

**The Chair:** Mr. Fonseca.

**Mr. Fonseca:** I'd like to thank you for your fine presentation. Our government does believe that when we work together, we're that much stronger in Ontario. Seeing the ODHA and the ODA working together in partnership to make sure that patients have more access: Can you tell me specifically what this will do for seniors in terms of dignity and respect for many who are in long-term-care homes?

**The Chair:** And you have five seconds.

**Ms. Clement:** I think Ms. Sasseville may have summarized that quite eloquently yesterday: just being able to provide services for them in their setting where they're most comfortable.

**The Chair:** Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Michelle. It's good to see you again. You too, Marg. I'm sure this is a really happy time. I know many hygienists and they do an outstanding job in providing patient services. So congratulations.

**The Chair:** Thank you for being with us.

#### ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS

**The Chair:** The next presentation is the Ontario Federation of Community Mental Health and Addiction Programs. The time is yours.

**Mr. David Kelly:** Hi. I'm David Kelly from the Ontario Federation of Community Mental Health and Addiction Programs. Besides being the longest acronym that you're going to deal with today, the federation works with over 220 mental health and addiction providers across the province, from Red Bay and the James Bay coast all the way down to Windsor. We work to build a better system of provision for people with mental health and addictions. These issues affect one in five Ontarians, and we hope to continue building a stronger and better system.

**1800**

I firstly want to thank the committee for allowing us this opportunity to come and talk to you today. I also want to thank each and every one of you on a personal basis for the support that you provide to people with serious mental illness and addictions and those providers in your communities. The complexity of these issues and the impact on you, your ridings, your homes, your friends and neighbours is tremendous. Quite honestly, it takes all of us to come together to build a better system. So again, please, my sincere thanks on behalf of our membership for your assistance.

We are here to talk about the regulation of psychotherapy and the Psychotherapy Act, 2006. First let me say that the federation is very, very supportive of building more regulations, better standards and higher quality within the mental health and addiction field. This is important for us to go forward, it's important for you to make sure that we are accountable for the dollars you



fund us, and it's very important for the people who are using these services. So first let me say that we are supportive of going forward with regulations.

We do have some concerns in this process and I'm going to try to highlight those for you now. The first one I want to highlight is the scope of practice. I won't read out the scope, but the problem with this definition is that only certain professionals may be able to legitimately engage in therapeutic relationships. This would draw a line between those who practise psychotherapy, who will be legitimized by the act, and those who do not; for example, peer counselling. Consumer survivor initiatives within mental health and peer counselling within the addiction systems could be negatively impacted by this.

For example, the government of Ontario funds, we know, about a million dollars' worth of consumer survivor initiatives in the southern part of Ontario. We know from that million-dollar investment, we save a total of over \$12 million in acute care costs because of this type of counselling. So it can be a very effective tool to help divert people from higher-cost services. But it's also the outcomes and the support that goes with having peer counselling. So we're just concerned that once we go forward with the scope of practice of that, other components of the mental health and addiction system could be negatively impacted.

Secondly, I'd just point to the controlled act. Many community-based mental health and addiction service providers work with people with serious disorders through a variety of therapeutic relationships. We are concerned, again, by framing it here, that this could impact negatively the duties they provide and the services they provide out into the community.

Thirdly, I point to the harm clause, which has been amended to read "serious bodily harm" rather than "serious physical harm." The effect of the amendment is to include emotional or psychological harm with a pre-existing physical harm. Again, this may mean that the regular work of community-based health workers could be captured as psychotherapy. Those who do not qualify as psychotherapists will be unable to complete their duties or face increased liability issues.

I touch on the liability issues again. Will people still refer to peer-based counselling in the community if it's not covered under psychotherapy? In a sense, will we be disenfranchised in some ways by the process of the regulations of psychotherapy? Again, I want to emphasize our support for the regulations and the building of a college, further standards and further best practices in our field. The government has done a great job. I know both opposition parties have worked toward that and, as I said, the issues are so complex that we need to come together for that.

What we are recommending—we know so many of these issues are going to be decided by the regulations that come out of the transition council. So we are encouraging the government to add to that, and with the people named from the public, a consumer of addiction and mental health services to ensure that perspective is

brought in, and people from the community-based services provision sector to ensure that those complex issues are addressed and met at the college.

Again, the federation is very supportive of going forward. Our concerns are that as we go forward in regulations, we will marginalize service providers in a system that is already marginalized.

**The Chair:** Thank you. Just over a minute each caucus, and we'll start with Mr. Mauro.

**Mr. Mauro:** Thank you very much, Mr. Kelly. I appreciate your presentation and your comments about the supportive intent and where we're going with this in the regulation of many of these unregulated professions.

I just would like to share a bit with you in terms of your comments and concerns around the peer counselling piece and some of those groups potentially being unable to continue to practise. In fact, as we see it, under scope-of-practice provisions in the new act, this will not restrict people who are not members of the college from entering into therapeutic relationships with clients. Using your example, it's our feeling and understanding that peer branch counselling would still be able to continue.

**Mr. Kelly:** That's encouraging to hear. But again, I just point at the intentions, and as we go forward I think you need to hear that voice and the college will need that.

We talk about consumers of mental health and addiction services being the centre of the system. Let's make sure they are here too. Thank you.

**The Chair:** Mrs. Witmer?

**Mrs. Witmer:** Thank you very much, Mr. Kelly, for your presentation. You've certainly pointed out that if some of these changes do not occur, it's going to have a negative impact on the delivery of mental health services in the province of Ontario. I guess I would say to you, what could the most serious threat be if the changes are not implemented?

**Mr. Kelly:** The most serious threat is, I think, that the government will actually lose opportunities to benefit from the interaction between peer counsel, which will actually increase our health care costs and waiting times for services. I also think that areas of the province will be disenfranchised because there will not be enough providers. We face a human resource crisis already in the health care system. We want to make sure those are addressed.

The real tragedy, as you're well aware, is that people often fall through the cracks of mental health and addictions. That's why we need this concerted effort to make sure that we go the right way.

**Mrs. Witmer:** Thank you very much. I would agree with you that there are a lot of cracks out there, and we certainly need all the providers who are currently providing service.

**The Chair:** Ms. Martel?

**Ms. Martel:** Thanks, David, for being here. I know that the government has said that they think peer counsellors in particular are going to be okay under the scope-of-practice provision. But if you look under the "restricted titles" provision, if peer counsellors aren't



defined as either psychotherapists or considered to be registered mental health therapists, then they can't use the title and they can't hold themselves out to do that. Then you've got a problem where people think that psychotherapists, because they have a title, are more qualified and they'd better be going there, or some agencies saying, "We're only going to send people there, not to peer counsellors."

I think the coalition earlier put forward a reasonable amendment that might help here, which is to have some other subcategories of folks who are included and who would have title protection. I wanted to know your views about having some other categories under registered mental health therapists and, if we have peer counsellors there, if that would solve all the problems.

**Mr. Kelly:** That may be a possible way to go. I would have to look at what their presentation was and their titles, but that may be an opportunity to start distinguishing. This could impact supportive housing providers. There are a lot of other components in the system. That may be a solution to us, and that's why I speak, again, to the need for us to be part of the college, not necessarily the federation, but for consumers and mental health and addition providers to be part of the college, because that way we can start looking and maybe going to those subcategories within the system to ensure that the workers who are presently helping people can continue to do so. That may be a very good solution.

**The Chair:** We're out of time. Thank you.

#### ONTARIO COLLEGE OF PHARMACISTS

**The Chair:** The last presentation is the Ontario College of Pharmacists. State your name for Hansard. You have 10 minutes.

**Mr. Gerry Cook:** Gerry Cook.

**Ms. Deanna Williams:** Deanna Williams.

**The Chair:** It's all yours.

**Mr. Cook:** Thank you, Mr. Chair and committee members. My name is Gerry Cook. I'm pleased to be here today in my capacity as president of the Ontario College of Pharmacists to provide our comments respecting Bill 171. With me today is our registrar, Deanna Williams, who will answer any questions you may have after the presentation.

The Ontario College of Pharmacists was established under the Pharmacy Act of 1871 and is the largest pharmacy regulatory authority in Canada. We currently regulate 11,000 pharmacists and 3,000 pharmacies.

Overall, our council strongly supports the amendments proposed in this bill, which we believe will streamline regulatory processes and enhance our ability to more effectively regulate the profession of pharmacy in the public interest. We are especially pleased that the proposed legislation gives effect to the regulation of pharmacy technicians as a new and separate class of registrant within the college.

#### 1810

Ontario is the first jurisdiction in North America to formally regulate pharmacy technicians, recognizing the need for trained, accountable and regulated professionals to ensure a safe and effective drug distribution system. Having regulated pharmacy technicians to oversee the technical aspects of dispensing will permit those pharmacists who choose to do so to move with confidence into the cognitive roles for which they have been trained.

The college council was, however, very disappointed that the government did not accept the HPRAC recommendation that health professionals earning a doctorate degree from an accredited university program be permitted to use the "doctor" title as a vocational designation. Soon pharmacists will graduate from the undergraduate program at the Leslie Dan Faculty of Pharmacy at the University of Toronto with a clinical doctorate in pharmacy, or a Pharm.D. degree. The college believes that these graduate pharmacists should be able to use the doctor title, with the caveat, as always, that the health discipline in which they are qualified to practise is clear to the public as well as to other health care providers.

Unlike other health colleges, the Ontario College of Pharmacists is unique in having both the right and responsibility to regulate the people, places and things associated with pharmacy practice in Ontario. The college regulates pharmacists—the people—under the authority of the Regulated Health Professions Act and the Pharmacy Act, and it regulates pharmacies and the sale of drugs—the places and things—under the authority of the Drug and Pharmacies Regulation Act. Accordingly, the proposed amendments to the DPRA in schedule L are of particular interest to this college, and I would like to highlight just a few of them right now for you.

Under the proposed legislation, pharmacists in Ontario will be able to fill prescriptions from prescribers licensed in other Canadian jurisdictions. This is good news for those patients living in northern and eastern Ontario who seek medical services in Manitoba and Quebec and currently cannot have their prescriptions filled when they return home. This amendment, which was approved by college council more than 10 years ago, brings Ontario into line with what is currently permitted in other provinces in the country.

Most important to this college are the enhanced powers under the proposed legislation that will enable us to act faster to close a pharmacy where there is clear or compelling evidence that continued operation of the pharmacy places the public at risk. When counterfeit product was discovered in a Hamilton pharmacy in 2005, the college successfully obtained an injunction from the provincial courts to close the pharmacy in five business days. This process would have taken between three to four weeks under the existing law, which is an unacceptable option.

The Ontario College of Pharmacists applauds the government's efforts in undertaking this enormous review and revision project. We are very pleased and satisfied



with the extensive consultation process undertaken by HPRAC, and we believe that the resulting legislative amendments, as proposed, are sound and well intentioned.

I'd just like to thank you for the opportunity to provide our comments. Deanna and I will be pleased to answer any questions that you may have.

**The Chair:** Any questions from Ms. Martel?

**Ms. Martel:** Thank you for being here today. I want to focus on the "doctor" title, because HPRAC made a recommendation—you're not the only group that has been here to talk about that, so I appreciate that. Do you have any sense of why that particular HPRAC recommendation is not being applied, either with respect to your professionals in the college or others who are similarly affected because they have the doctoral level of education that would allow them to do that?

**Ms. Williams:** We don't really have a sense as to why that might be the case. It could be from a public protection standpoint.

Certainly, the caveat that our college would apply—and we would hope that everyone would—would be that the discipline in which the health professional is trained be clear to the public. There may be some concerns that someone putting a "doctor" name tag on could give the public the wrong information or it could imply that they're a medical doctor, so we would certainly put it in the standard of practice and expect that any pharmacists who use the "doctor" title would clearly indicate that they're a pharmacist.

**Ms. Martel:** And if not, they'd be subject to the discipline of their particular college. The protection

comes from the college being able to take disciplinary action against someone who does something untoward in that regard; so my assumption is that the colleges are perfectly capable of doing that. A number of them have been around for a long time and could exercise that, if warranted.

**The Chair:** Mr. Fonseca?

**Mr. Fonseca:** I'd like to thank the Ontario College of Pharmacists for your comments on the protection of patients and also the access that this will open up.

We've often had the OPA come in and present to us. Can you tell me a little bit about how the OPA feels about your submission, and do they support what you've requested here or some of the comments that you've made?

**Ms. Williams:** The college has consulted pretty widely on all of the regulatory proposals that are contained within Bill 171 over the years. The OPA is certainly one of our key stakeholders, as are the association of chain drug stores and hospital pharmacy. At the OPA's request, we did give them a copy of the presentation that we were doing today, and they did indicate support for it.

**The Chair:** Thank you. That concludes our presentations.

I'll remind the committee that proposed amendments must be filed with the clerk by 12 noon on Friday, May 4, and this committee will meet for the purpose of clause-by-clause consideration on Monday, May 7.

We have managed, amazingly, yet again, to finish at precisely 6 o'clock. This committee is adjourned.

*The committee adjourned at 1816.*





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**Legislative Assembly  
of Ontario**

Second Session, 38<sup>th</sup> Parliament

**Assemblée législative  
de l'Ontario**

Deuxième session, 38<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

**Monday 7 May 2007**

**Journal  
des débats  
(Hansard)**

**Lundi 7 mai 2007**

**Standing committee on  
social policy**

Health System  
Improvements Act, 2007

**Comité permanent de  
la politique sociale**

Loi de 2007 sur l'amélioration  
du système de santé



Chair: Ernie Parsons  
Clerk: Trevor Day

Président : Ernie Parsons  
Greffier : Trevor Day

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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Monday 7 May 2007

Lundi 7 mai 2007

*The committee met at 1542 in committee room 1.*HEALTH SYSTEM  
IMPROVEMENTS ACT, 2007  
LOI DE 2007 SUR L'AMÉLIORATION  
DU SYSTÈME DE SANTÉ

Consideration of Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts / Projet de loi 171, Loi visant à améliorer les systèmes de santé en modifiant ou en abrogeant divers textes de loi et en édictant certaines lois.

**The Chair (Mr. Ernie Parsons):** I would like to call to order the standing committee on social policy. We are all trapped inside on this beautiful, sunny day to deal with amendments and clause-by-clause of Bill 171.

If all members are in agreement, we would like to stand down at this time sections 1, 2 and 3 and deal with the schedules initially, and then return at the end and do the three sections. Do we have agreement on that?

We will move first to amendment 1.

*Interjection.*

**The Chair:** Oh, no amendments here? Okay. We actually get to vote early on.

Shall schedule A, sections 1 to 4 inclusive, carry? Carried.

Shall schedule A carry? Carried.

Schedule B: We're not aware of any proposed amendments to schedule B, sections 1 to 13. Shall schedule B, sections 1 to 13 inclusive, carry? It is carried.

Schedule B, section 14: We are now going to deal with amendment 1, which is an NDP amendment.

**Ms. Shelley Martel (Nickel Belt):** Before I start, I want to thank the legislative counsel, Ralph Armstrong, for his help with all these amendments. I know he had two bills to deal with last week, so I appreciated his working overtime to get these done. Thank you very much.

I move that section 14 of schedule B to the bill be amended by adding the following subsection:

"(0.1) Paragraph 3 of subsection 5.1(1) of the Nursing Act, 1991 is repealed and the following substituted:

"3. Prescribing or dispensing a drug.

"3.1 Setting or casting a fracture of a bone or dislocation of a joint.

"3.2 Applying or ordering the application of a form of energy prescribed by regulation."

**The Chair:** Thank you. I'm afraid I have to rule this amendment out of order, as subsection 5.1 of the Nursing Act is not open.

**Ms. Martel:** Can I just ask for a clarification? The Nursing Act is being amended on page 9 of the bill.

**The Clerk of the Committee (Mr. Trevor Day):** Section 5.1 of the act is not open.

**Ms. Martel:** So that particular section has to be open before we can move the amendment, even though the Nursing Act is being amended under this schedule?

**The Clerk of the Committee:** Yes.

**Ms. Martel:** Okay, Mr. Clerk, I would never want to—

**The Chair:** He's smarter than me. If he says that's it, that's it.

**Ms. Martel:** So just to be clear so that it's on the record: It's being ruled out of order?

**The Chair:** It's being ruled out of order. That's correct.

Is there any additional debate on schedule B, section 14? Hearing none, shall schedule B, sections 14 to 19, carry? Carried.

*Interjections.*

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** I would ask for unanimous consent that we go back to schedule B to the bill, section 5.

**The Chair:** There has been a request for unanimous consent to revisit schedule B, section 5. Do I hear—

*Interjection.*

**The Chair:** I'm not sure what I heard so I will ask again.

**Mr. Khalil Ramal (London-Fanshawe):** No. We dealt with it.

**Mrs. Witmer:** I guess we have the answer. I guess people aren't too interested in making changes to this act.

**Mr. Ramal:** Sorry, we didn't see that amendment. We didn't have the amendment.

**The Chair:** Okay. I'm not that good hearing in my right ear. I'm going to ask one more time because I did not hear well. Do we have unanimous consent to reopen section 5?

*Interjection.*

**The Chair:** Hearing no "No," I have agreement. Mrs. Witmer, we will return to section 5.

**Mrs. Witmer:** Okay. I would like to move that clauses 5(1)(a) and (b) of the Dental Hygiene Act, 1991,

as set out in schedule B to the bill, be struck out and the following substituted:

"5(1) A member shall perform a procedure under the authority of paragraph 1 of section 4 in accordance with any requirements prescribed in the regulations, and may perform such a procedure,

"(a) on the member's own initiative,

"(i) if none of the contraindications prescribed in the regulations to performing the procedure are present, and

"(ii) as long as the member ceases performing the procedure should any of the prescribed contraindications to continuing to perform the procedure be present, or

"(b) if the procedure is ordered by a member of the Royal College of Dental Surgeons of Ontario."

This is being introduced. It doesn't change the intent of the schedule. It simply clarifies what the intention is. If you go back and you take a look at the original amendment, this clarifies (a) in particular, (i) and (ii).

**The Chair:** Any debate? Mr. Fonseca?

**Mr. Peter Fonseca (Mississauga East):** We'll say no, and we'll ask legislative counsel to clarify. The ministry will clarify.

1550

**The Chair:** If you would state your name for Hansard.

**Mr. Ryan Collier:** Ryan Collier. Can I get clarification on the number of the bill that is being amended? Which section of the schedule?

**Mrs. Witmer:** Schedule B to the bill, section 5.

**Mr. Collier:** Section 5?

**Mrs. Witmer:** Yes.

**Mr. Collier:** It deals with the Dental Technology Act?

**Mrs. Witmer:** It's 5(1)(a) and (b). It's a substitution for what's written here in order to provide clarification. I don't believe it changes the intent.

It's section 4 of our bill, which is actually section 5 of the Dental Hygiene Act.

**The Chair:** Well, the first problem is, we've reopened the wrong section.

Because we've reopened section 5, we now need to close it, so I'm going to ask, shall section 5 carry? Carried.

Now, in order to deal with the amendment that is proposed, we require unanimous consent to reopen section 4. Do I have unanimous consent? We've got a no. I heard a no.

Moving next to—

**Mrs. Witmer:** Mr. Chair, as I move forward today with the clause-by-clause of this particular piece of legislation, Bill 171, I just want to get it on the record: I have grave concerns about the introduction of this omnibus bill. I have grave concerns that many of the stakeholders are just starting to understand the consequences of what is contained herein. I personally don't believe that those of us in opposition have the resources to introduce the huge number—hundreds—of amendments that could possibly have been introduced today. When I think of how much time we spent on the Chinese act—the acupuncture and the TCM and what have you; the traditional Chinese—I'll tell you, I find it unbelievable that we

would sit here and we would push this bill through as quickly as we have. I don't think there has been enough consultation with the stakeholders. Many of the amendments here, the act, are a deviation from the recommendations of the report done by Barbara Sullivan. I'm afraid, in our haste, we're not going to have a bill that really responds to the needs and protection of the public as it should. That's throughout the entire body of the bill; I have grave concerns about our ability to do justice to the bill in making it the best it can be for the public and the province of Ontario.

**Mr. Fonseca:** For this piece of legislation, we have consulted widely with all stakeholders. We've heard from all stakeholders; they have brought forward improvements to this piece of legislation. That's what we're going through here today.

It was brought forward in December of last year. It's about transparency; it's about emergency preparedness; it's about improving our health care system, and we must move forward, Mr. Chair.

**Mr. John O'Toole (Durham):** I just want to support Ms. Witmer's observation—just now in my own riding, as each of us has a responsibility to consult with those individuals in professions—that it is being rushed. It's an omnibus bill, and I think as a courtesy we should at least read the amendments and then understand them—have legislative counsel, who are involved in drafting this, because it is very technical and highly problematic for a number of what I'd call subordinate stakeholders in health care provision in a changing society where other treatment modalities are preferred.

You have a doctor over there. I'm sure comment during this clause-by-clause is extremely important. I'm concerned, if we rush an omnibus bill through without taking the courtesy of time, we won't do service to the people of Ontario.

**The Chair:** Okay. We'll proceed, then, to amendment 2, which is part of schedule B, section 20.

**Ms. Martel:** I move that section 20 of schedule B to the bill be amended by adding the following subsection:

"(0.1) Subsections 8(1) and (2) of the Psychology Act, 1991 are repealed and the following substituted:

"Restricted titles

"8.(1) No person other than a member shall use the title 'psychologist' or 'doctoral psychologist,' a variation or abbreviation or an equivalent in another language.

"Representations of qualification, etc.

"(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychologist or doctoral psychologist or in a specialty of psychology."

**The Chair:** I am afraid I have to rule that out of order, as section 8 of the Psychology Act is not open at this time.

**Ms. Martel:** If I might, I would ask for unanimous consent for the committee to hear the reason I would like to have this moved forward.

**The Chair:** There has been a request for unanimous consent to consider amendment 2. Do I have unanimous consent? Yes.



**Ms. Martel:** I appreciate that. I'm going to go as quickly as I can. I hope the committee will bear with me, because this comes from a presentation that we did not hear orally during the public hearings because there just wasn't enough time to hear enough groups. But it is a presentation that all of us were sent, a submission to the committee by the Ontario Association of Psychological Associates. So that is where the amendment comes from, and the reasoning is this. As quickly as I can, I'm just going to read into the record portions of their submission which outline the reason I'm moving forward with the change.

"A two-titled system for the College of Psychologists was set up in 1991 with the passing of the Regulated Health Professions Act and the Psychology Act. Doctoral-level members were to be called 'psychologists' and master-level members were to be called 'psychological associates.' Based on the 13 years' experience since over 500 psychological associates were accepted into the college, this two-titled system was an experiment that has not served the public or the profession particularly well.

"The restricted title 'psychological associate,' as contained in section 8(1) of the Psychology Act, has been a source of major confusion for the public seeking high-quality health care. The title has been a frequent barrier to clients seeking reimbursement from both private insurance companies and public agencies for services regulated and approved under both provincial and federal legislation.

"Reimbursement for psychological assessments, psychotherapy and other interventions by psychological associates has been denied or delayed while families worry and wait. The cause is confusion over the title: Insurance companies and government agencies continually question the regulated and autonomous status of psychological associates providing the service. Sometimes these reimbursement decisions are reversed and sometimes they are not.... Because insurance policies and government service programs are often tied to the term 'psychologist' so as to accommodate regulatory models across the country, the title 'psychological associate' can result in refusal. After 13 years, OAPA and the College of Psychologists still regularly need to intervene on behalf of clients with programs such as the Ontario disability support program, the Workplace Safety and Insurance Board, the statutory accidents benefits schedule and the tax credit program for the disabled. Recently, an issue with the federal disability tax credit seemed resolved via a letter from Minister Flaherty, yet clients of psychological associates are still having tax credit claims denied. Our confusing and unrecognized title creates a needless barrier which has proven very resistant to many efforts by OAPA and the College of Psychologists to educate and inform third-party payers....

"We would like to point out that psychological associates have the same or equivalent registration requirements for autonomous practice as psychologists do. They become eligible to apply for registration after a minimum

of 11 years of preparation: four years in undergraduate psychology programs, a minimum of two years in graduate programs and four years in relevant professional practice. Their academic coursework must cover the same core areas as psychologists. In addition, candidates for both titles must have at least one year on the college's register for supervised practice. Candidates for both titles must also pass the same demanding written and oral exams....

"The current composition of the College of Psychologists in Ontario is 80% doctoral-level and 20% master-level members. The college has not been able to remedy the difficulties over title. The solution of adopting one title 'psychologist' must come from outside the college. The options are (1) through the court system or (2) through the legislative process by way of an amendment to the Psychology Act.... The second option is available to the committee now.

"We ask the minister and members of this standing committee to reach a consensus on an amendment to the Psychology Act, 1991 to resolve this title issue and provide clarity, consistency and ease of access for residents of Ontario to this essential health care service."

#### 1600

The recommended wording is used in the Saskatchewan legislation, and they propose that it be amended to read: "No person other than a member shall use the title 'psychologist' or 'doctoral psychologist,' a variation or abbreviation or an equivalent in another language."

This has been in place in Saskatchewan since 1997 under subsection 24(1) of Saskatchewan's Psychologists Act. What it does is permit all members of the Saskatchewan College of Psychologists to use the title "psychologist." Section 20 of the act requires the members of the college to be in possession of either a master's or a doctoral degree in a program consisting primarily of psychology classes from an educational institution recognized by the council. However, subsection 24(2) of the act limits the use of the title "doctoral psychologist" to those members of the college who have doctoral degrees.

I'm moving the amendment on behalf of the association in the hope that there will be no further confusion around psychologists versus psychological associates. For those who have additional degrees or additional education, they would certainly be permitted to use the title "doctoral psychologist" but, once and for all, I trust it would end the confusion that comes from insurance companies etc. not wishing to sign for reimbursement of services provided by psychological associates because they consider them to be of a lesser standing, have lesser education, lesser competencies and capabilities than those who use the title "psychologist." That is the purpose and the intent of the amendment.

**The Chair:** Thank you. Any further discussion? Hearing none, I will call the vote. Those in favour of the amendment? Those opposed? The amendment is lost.

Shall schedule B, section 20, carry? It is carried.

Shall schedule B, sections 21 to 24, carry? Carried.

Shall schedule B carry? It is carried.

That moves us now to schedule C. Shall schedule C, sections 1 to 4, carry? Carried.

Shall schedule C carry? Carried.

Schedule D, section 1: We now have an amendment from the official opposition.

**Mrs. Witmer:** I move that section 1 of schedule D to the bill, amending the Health Protection and Promotion Act, be amended by adding the following section:

“(3.1) Section 5 of the act is amended by adding the following section:

“Cost of water testing

“(2) Despite paragraph 1.1 of subsection (1), the cost of testing water in small drinking-water systems shall be borne by the province and shall result in no additional costs being borne by boards of health.”

**The Chair:** Because this adds a cost component for the government, I have to rule this amendment out of order.

**Mr. O'Toole:** Chair, could we get a response on the government's intention going forward on source water protection? Bill 43 specifically has raised a fairly high level of concern in rural and northern Ontario about metering and then charging for water from wells. This is out there. Is there anything in this bill that could end up costing people money? As Chair, you've ruled that this is out of order because it implies costs, so there are costs.

**The Chair:** This indicates that there is a requirement for government of that. I have to rule it out of order. This amendment is now completed, so we cannot debate it. If you wish to debate this concept, you can debate it when we have the motion dealing with section D. I'm not ruling it can't happen, but it can't happen under this particular motion.

**Mr. O'Toole:** Yes. I think, for clarification and on the record, our concern on Bill 43 was not safe water; it's the fact that it's being downloaded. The costs, which have not been fully disclosed, despite the \$24 million and the \$120 million, are going to be borne at the municipal level in your water bill. This is the concern.

**The Chair:** I'm not disagreeing with what you're saying. I'm disagreeing with the process. If you wish to speak to that, first of all we need to move schedule D. Once we have a motion, then you can speak to it and debate it.

I am about to ask, shall schedule D, section 1, carry? Any discussion? Are you finished?

**Mr. O'Toole:** No. My point there was the same. I'd like to have, on the well issue, a recorded vote that there will be no costs. It's my understanding there will be no costs downloaded to the municipal tax bill or other bill issued by way of the orders in this act. I'm concerned about the consultation. This is something we all share. We all want safe, clean drinking water but we want it done openly so that people, whose lives and welfare depend on safe, clean drinking water—which we all support—have a full understanding of the implications for rural and remote parts of Ontario.

**Mr. Fonseca:** Mr. Chair, what we're bringing forward, if passed—AMO first asked for this, and it is much less stringent than what we had under MOE. A letter was sent by the ministry to all public health units on April 3 of this year, which said if the legislation passed, provincial support would be provided on a 100% basis for start-up costs, including an initial planning period, followed by a two-year period of conducting the initial site-specific risk assessments. They referred to the fact that technical laboratory supports necessary for the work for public health inspectors would need to be in place. This included the funding of the related laboratory testing, which would be covered for all health units.

**Mr. O'Toole:** So the implication is that the costs associated with testing today under public health is borne by the public and in the future will be charged when you bring in the little bottle.

**Mr. Fonseca:** Yes. I'll repeat: All the start-up costs and an initial planning period of two years will be ministry-provided.

**Mr. O'Toole:** And going forward there would be no further costs. When I bring in the little testing bottle, I get the bill. Ultimately, that would be a change. We've been ruled out of order, as Mrs. Witmer, our critic in health, has drawn to your attention. I'm sure all members here—I'm satisfied that they support raising this surreptitiously and we don't. We're all in favour of clean drinking water; only, who is paying is the issue.

**The Chair:** Any additional discussion on schedule D, section 1?

**Ms. Martel:** Just on a point raised by Mr. O'Toole, I wonder if the parliamentary assistant can make available a copy of the letter he referenced to the two opposition health critics?

**Mr. O'Toole:** We will need that during the election. You'll say we voted against clean water, and we didn't. We voted for accountability and transparency.

**Mr. Fonseca:** You just said you voted against clean water.

**Mr. O'Toole:** You said it today in the House.

**Mrs. Witmer:** We didn't vote against clear water. We just wanted to make sure that you were going to pay for it, not download it.

**Mr. O'Toole:** Exactly; transparency. The people who are here from health know how important water is to humans and other species—plants—but they portray this—

**The Chair:** Mr. Arnott, you're a Deputy Speaker. What happens when you lose control? Give me some advice.

**Mr. Ted Arnott (Waterloo–Wellington):** I resign.

**Mrs. Witmer:** He said to resign.

**The Chair:** Tempting as that is—okay, if there is no additional debate—

**Mr. O'Toole:** We would ask for a recorded vote on this one.

**The Chair:** Shall schedule D, section 1, carry?



**Ayes**

Fonseca, Kular, Martel, Milloy, Ramal, Sandals.

**The Chair:** It is carried.

Shall schedule D, sections 2 to 4, carry? Carried.

Shall schedule D carry? It is carried.

Shall schedule E, sections 1 to 3, carry? Carried.

On schedule E, section 4, we have an NDP amendment.

**Ms. Martel:** I move that section 10 of the Immunization of School Pupils Act, as set out in section 4 of Schedule E of the bill, be amended by adding the following subsection:

“Report

“(2) The physician or member shall, with the consent of the parent, forward a copy of the statement to the medical officer of health for the health district in which the child resides.”

1610

If I could speak to it, this comes from a presentation that was made to the committee by Dr. Rosanna Pellizzari, who is the medical officer of health for the Perth district board of health. You will recall that she raised with the committee her serious concerns, as but one medical officer of health, about the number of times they discovered that immunization reports are not updated on school files and that children are then at risk of being suspended from school until such time as that immunization record can be provided to the health unit. In many cases, the immunization has already taken place, but there has been no mechanism to provide that particular information to the health unit.

She also mentioned that it had been a significant cost for their particular board of health, both in human and financial resources, to work with the various school boards to try to sort out where immunizations had been done this year, and if we had a mechanism whereby, with the parents' consent, the physician who provides the immunization sends a copy of that to the board of health, it would significantly decrease the work the board has to do to sort this out later. So it's being moved as a result of her presentation.

**Mr. Fonseca:** One of the challenges to this would be operationalizing this legislative requirement. What the ministry is looking at is best practices in data collection as we move forward on e-health. At this time, it would not be prudent for us to move forward on this.

**Ms. Martel:** If I might, I don't know how long it's going to take for the government to move forward on e-health. We've been moving forward on e-health for quite some time, and we are nowhere near to being adequately linked in the province through physicians' offices to hospitals etc. If you want to figure out something later on e-health, that's fine with me, and we can incorporate that at the time. I do think, because this is a problem not just in Perth county but right across the province, that as an interim step until the government sorts out where e-health is going, we could put this mechanism in place

to ensure that boards of health are aware that children have been immunized so that we don't have further resources being spent by the board of health, and then by the school and the school board, determining which child should be suspended and which shouldn't. This is a no-brainer, from my perspective, and would resolve a lot of problems at the health units right now, because they don't have that information.

**Mr. Fonseca:** We are committed to data collection and improving our data collection, and to e-health. In this last budget, \$64 million was set aside for our e-health strategy. But we are also consulting with our physicians and other health care providers to see the best way to collect this data. There are also some privacy implications, as we look at this legislation.

**Ms. Martel:** If I might, I don't know where the privacy concerns are. It says “with the consent of the parent.” As long as consent is provided by the parent to the physician to provide a copy of the immunization record to the chief medical officer of health or the health authorities, I don't see where the privacy issues are.

The final question I'd like to ask the parliamentary assistant is, how long does he think it will be till we have something in place that would respond appropriately to Dr. Pellizzari's concern? I can tell you that it's not just her concern, but a concern with all medical officers of health right across the province.

**The Chair:** Further debate?

**Ms. Martel:** I'd just like an answer about how long it is going to take before we have a solution—any solution—to this.

**Mr. Fonseca:** It is actually being worked on presently through the LHINs, in terms of the data collection. The LHINs are working on this.

**Ms. Martel:** They're working on a system to have this work?

**Mr. Fonseca:** Presently; that's what I have here.

**Ms. Martel:** But their response could vary from LHIN to LHIN, correct, on how this is implemented?

**Mr. Fonseca:** What I've got is “the LHINs,” so that would be all LHINs.

**Ms. Martel:** Yes. I'd like a recorded vote on this, Chair.

**The Chair:** Further debate?

**Mr. O'Toole:** If I may, the parliamentary assistant seems to have a fairly good idea on this. I was on the Smart Systems for Health board—

**Mr. Fonseca:** Just a clarification: I am not the parliamentary assistant.

**Mr. O'Toole:** Well, you're doing all the answering, which is fine. Who is the parliamentary assistant?

**Mr. Fonseca:** It was Tim Peterson. He's now—

**Mr. O'Toole:** Oh, Tim, and he was so disappointed, he crossed the floor. Anyway, that's a whole other issue.

**The Chair:** This was the issue that did it, was it?

**Mr. O'Toole:** On Smart Systems for Health, could we ask, through this committee, for an update on how much has been spent, and of the nine modules, what's deliverable? A lot of the implications on this and the regulations

etc. are dependent on having this great, huge Smart Systems e-Health thing in place. Could we have a date and an update on that? It's a fair question, because a lot of these questions emanate around health privacy, consent, informed consent and implied consent.

**Mr. Fonseca:** Smart Systems actually does an annual report, and that annual report is tabled in the House.

**Mr. O'Toole:** So it's not operational, then.

**Mr. Fonseca:** There's an annual report that is tabled in the House.

**Mr. O'Toole:** Spending money; that's good.

**The Chair:** If there's no further debate, I will call the vote. There has been a request for a recorded vote.

### Ayes

Martel, O'Toole, Witmer.

### Nays

Fonseca, Kular, Milloy, Ramal, Sandals.

**The Chair:** The amendment is lost.

Shall schedule E, section 4, carry? Carried.

Shall schedule E, sections 5 and 6, carry? Carried.

Shall schedule E carry? Carried.

That brings us to schedule F. Shall schedule F, section 1, carry? Carried.

There is a new section, the NDP, and that is amendment 5. Ms. Martel.

**Ms. Martel:** I move that schedule F to the bill be amended by adding the following section:

"1.1 Section 4 of the act is amended by adding the following subsection:

"Precautionary principle

"(2) A board of health shall not await scientific certainty before acting."

This recommendation came to us by both the Ontario Nurses' Association and the Registered Nurses Association of Ontario.

**The Chair:** I have to rule the amendment out of order.

**Ms. Martel:** Okay. Then I will ask for unanimous consent for me to outline the motion and why it's being put.

**The Chair:** There has been a request for unanimous consent to consider amendment number 5. Do I hear consent? Yes.

**Ms. Martel:** Thank you, Chair.

Very briefly, both the Ontario Nurses' Association and the Registered Nurses Association of Ontario in their presentations before the committee suggested very strongly that the government heed the recommendations that had been made in the Campbell report. There are a number of recommendations, and I will reference them in several of the amendments we've put forward. I'm just going to quote from ONA's presentation to the committee, which said as follows:

"However, we urge the government to heed the recommendation of the Campbell report to incorporate

the precautionary principle into the act. We would recommend that the precautionary principle be incorporated in the duties of boards of health into part II, section 4 of the act." That's what this amendment proposes to do.

**The Chair:** Further discussion?

*Interjection.*

**The Chair:** I'm going to call the vote. I've had a request for a recorded vote.

### Ayes

Martel, O'Toole, Witmer.

### Nays

Fonseca, Kular, Milloy, Ramal, Sandals.

**The Chair:** The amendment—

**Mr. O'Toole:** Just to the clerk, I'm wondering why, in all fairness, if legal counsel is advising that these things are out of order, and as a courtesy Mr. Fonseca is allowing Ms. Martel or Mrs. Witmer to read the amendment, why are we voting on it? Or are you just voting on the section?

1620

**The Chair:** It is out of order because that section is not open, and so unanimous consent allows it to be opened.

**Mr. O'Toole:** You're just voting on the section, ignoring it.

**The Chair:** The unanimous consent is to allow the committee to consider it anyway, and it can be done if there's unanimous consent.

**Mr. O'Toole:** You're allowing unanimous consent to open a section that was not otherwise open. I think that, through the Chair, you might just ask that first, when somebody submits an amendment, if it's out of order, and that's the end of it.

**The Chair:** I'll bear that in mind my next term.

Shall schedule F, sections 2 to 13, carry? Carried.

We now have a new section, which is amendment number 6, a Progressive Conservative motion.

**Mrs. Witmer:** I move that schedule F to the bill be amended by adding the following section:

"13.1 Section 62 of the act is amended by adding the following subsections:

"Report, CMOH

"(3) The annual report of the chief medical officer of health shall include a status report with respect to vacancies among medical officer of health and associate medical officers of health and among physicians in the public health division, and a report as to activities taken to fill vacancies.

"Where failure to appoint

"(4) Where a board of health has failed to appoint a medical officer of health, the chief medical officer of health shall appoint an assessor to investigate the situation and make recommendations.



“Additional powers, MOH

“(5) A medical officer of health has, subject to accountability to the board of health, full chief executive officer authority for local health services,

“Same

“(6) Every medical officer of health has the same authority as the chief medical officer of health to speak out about and to manage local outbreaks of infection.”

**The Chair:** It is out of order, as section 62 of the Health Protection and Promotion Act is not open. You could request unanimous consent.

**Mrs. Witmer:** Sure, I could request unanimous consent, and I will.

**The Chair:** There has been a request for unanimous consent to consider amendment number 6. Is there unanimous consent? Agreed.

**Mr. Fonseca:** For this?

**The Chair:** I’m going to ask if there is unanimous consent to consider amendment number 6. Agreed? It is agreed.

**Mr. Fonseca:** I’d like to move an amendment, Chair.

**The Chair:** You wish to move an amendment to the amendment?

**Mr. Fonseca:** Correct. Schedule F to the bill, section 13.1, Mrs. Witmer’s motion.

I move that Mrs. Witmer’s motion to add section 13.1 to schedule F of the bill be amended to read as follows:

“13.1 Section 62 of the act is amended by adding the following subsection:

“Report, CMOH

“(3) The annual report of the chief medical officer of health under section 81 shall include a summary of the medical officer of health and associate medical officer of health vacancies in Ontario.”

**The Chair:** We are now, I believe—because there has been an amendment made to the amendment—debating the government amendment, which has been distributed. Any further discussion on the amendment to the amendment?

**Ms. Martel:** I should point out that Mrs. Witmer’s amendment is the same as mine, which is coming next. We were told that the government was going to move a friendly amendment—that’s fine. What worries me about what I see the government moving is that three sections that appear in my amendment and Mrs. Witmer’s are now dropped from the government amendment. That’s not as friendly as I thought it was going to be, to be quite blunt about it.

I agree with provision 1, that there should be an annual report and it should include a summary of the vacancies of medical officers of health. But I also agree, as per the presentation that was put to us by the chief medical officers of health across the province, that the remaining other three should also take effect. For example, if every medical officer of health has the same powers as the chief medical officer of health around exercising powers in good faith, if there has been a failure to appoint, then the chief medical officer of health

shall appoint an assessor, and also, they have the same authority.

I’m a bit concerned that there have been some things that have been dropped here that were put forward in both Mrs. Witmer’s and my amendments. I don’t really know why those things have now been dropped.

**The Chair:** Mrs. Witmer.

**Mrs. Witmer:** I could not support this amendment to my amendment because I have grave concerns about what is being omitted. We need much more than an annual report telling us the number of vacancies. For example, we know at the present time 12 of 36 are in that position. What we need to do is make sure that we can take action on filling those vacancies.

In listening to the medical officers of health, they are very concerned about the inability to fill these vacancies and obviously the impact that it’s going to have in this particular situation; we talk about managing local outbreaks of infection. So I could not support this amendment.

**The Chair:** Any further debate?

**Mr. Fonseca:** I would just bring clarification that subsections (4), (5) and (6) are not necessary because they are redundant. I’ll give you an example. Subsection (5): The chief medical officer of health already has the power to appoint an assessor to examine the MOH vaccines where deemed necessary; that’s in section 82. It would be inappropriate for assessors to have to always be appointed, in that the reason for the board’s failure may be the shortage of medical officers of health in the health unit or the province and outside the board’s control. There is also reasoning for subsections (4) and (6), if you’d like it.

*Interjection.*

**The Chair:** Ms. Martel had her hand up first.

*Interjection.*

**The Chair:** You defer to Mrs. Witmer?

**Mrs. Witmer:** My concern is, even in subsection (3) in my amendment and Ms. Martel’s, we talk about not only identifying the vacancies; we talk about the need for a report to identify what activities should be undertaken to fill those vacancies. That’s extremely important, and that is nowhere in this new amendment. I think the issue is not who’s there, but who’s not there, and how are you going to make sure that we do have all of these positions filled? We’ve seen this situation worsen in recent years, and it is of grave concern to local medical officers of health and their ability to deal with situations locally.

**The Chair:** Further discussion? Hearing none, I will call for the vote on the amendment to the amendment. Those in favour? Opposed? The motion is carried.

Is there any additional discussion on the amendment as amended?

**Ms. Martel:** Can we have a recorded vote?

**Mr. O’Toole:** The amendment carried, so it applies that the amendment, as amended, carries.

**The Chair:** No. There needs to be a vote on the original amendment.

**Mr. O’Toole:** We just passed a motion on the amendment.

**The Chair:** Yes, which is now an amended amendment. If I have in any way given an indication that I know what I'm doing, I apologize for that. It is misleading. We will now vote—

**Ms. Martel:** I'm sorry, Chair. I don't want to prolong this. I'm assuming our next vote is on Mrs. Witmer's amendment?

**The Chair:** Mrs. Witmer's, as amended, yes.

**Ms. Martel:** So the first vote was on Mrs. Witmer's before it was amended—the one that we just took.

**The Chair:** No. The first vote was on the government amendment to the official opposition amendment. The amendment to the amendment has now passed. I would now like to call the vote on the amendment.

**Mrs. Witmer:** But isn't it really just a replacement?

**The Chair:** The amendment has had the effect of replacing Mrs. Witmer's motion with the government motion—

**Mrs. Witmer:** Right.

*Interjections.*

**The Chair:** —but it is still the official opposition's motion.

**Mr. O'Toole:** Well, I might just add to that that this is a new section. We have adopted an amendment. The government has forced this amendment to the amendment, which added a section, and it nulls the other amendment.

**The Chair:** Yes.

**Mr. O'Toole:** So why are we voting on it?

**Mrs. Witmer:** Good question.

**The Chair:** Because we're required to vote on the original motion, as amended.

*Interjections.*

**The Clerk of the Committee:** Sorry; if I may, Mrs. Witmer had a motion she put on the floor, and we had that. Before we could vote on that motion, the government suggested that we change that motion, that we amend it. We voted on that amendment, and it is now changed. It's still on the floor, but it's changed. Now that it's changed, we have to vote on that original motion, as it was amended, to see if 13.1 becomes a section to this bill.

**Mr. O'Toole:** So, logically, we would vote against this—

**The Chair:** I do not give advice on how one votes.

**Mr. O'Toole:** Well, I am going to give you some. We would vote against it because it doesn't do what it's intended to do.

**The Chair:** I'm conscious of the clock, and I'm going to give you the opportunity to do that.

**Ms. Martel:** Chair, very quickly, because we have concerns—I think the concerns are similar—that the government amendment is far less than what is necessary and what we put forward, I just want to be clear that if we vote against the next motion that you're putting on the floor, the sum total of that is for us to be able to express our concern with what the government has done and that the government didn't accept an amendment that would have been much fuller and, from our perspective, a much better amendment.

Is that the end result? I'm a little bit nervous now.

**The Chair:** I'm going to call the vote. Those in favour of the amendment, as amended? Those opposed? It is carried.

I am now going to call a recess in order for the committee to attend at the vote, and we will recommence immediately after. The committee is in recess.

*The committee recessed from 1632 to 1643.*

**The Chair:** The committee is back in session. This brings us to NDP motion 7.

**Ms. Martel:** This is a motion that's similar to the one that Mrs. Witmer moved and that was amended in a less than satisfactory way by the government. But the dilemma is that it's essentially the same, so I will have to withdraw it.

**The Chair:** The amendment is withdrawn.

We move now to schedule F, section 14. The first item to deal with is government amendment 8.

**Mr. Fonseca:** I move that section 77.5 of the Health Protection and Promotion Act, as set out in section 14 of schedule F to the bill, be amended by adding the following subsection:

“Other provinces and territories

“(1.1) Nothing in this section shall require a person subject to an order to provide to the minister or to another person specified in the order a quantity of medications and supplies if there exists or may exist an immediate risk that the health of patients in another province or territory of Canada would be jeopardized.”

**The Chair:** Do you wish to speak to the amendment?

**Mr. Fonseca:** No.

**The Chair:** Any additional discussion?

Hearing none, shall amendment 8 carry? It is carried.

That brings us to Progressive Conservative motion 9.

**Mrs. Witmer:** I move that section 77.5 of the Health Protection and Promotion Act, as set out in section 14 of schedule F to the bill, be amended by adding the following subsection:

“Appeal

“(9.1) An order under this section may be appealed to the Superior Court of Justice within 30 days of being made.”

**The Chair:** Do you wish to speak to the motion?

**Mrs. Witmer:** No.

**The Chair:** Any additional discussion? I will call the vote, then. Those in favour? Those opposed? The motion is lost.

That brings us to government motion 10. Mr. Fonseca?

**Mr. Fonseca:** I move that section 77.7 of the Health Protection and Promotion Act, as set out in section 14 of schedule F to the bill, be amended:

1. By adding the following subsection:

“Precautionary principle

“(1.1) In issuing a directive under subsection (1), the chief medical officer of health shall consider the precautionary principle where,

“(a) in the opinion of the chief medical officer of health there exists or may exist an outbreak of an infectious or communicable disease; and



“(b) the proposed directive relates to worker health and safety in the use of any protective clothing, equipment or device.”

2. By adding the following definition to subsection (5):

“‘precautionary principle’ has the meaning prescribed in regulations made by the Lieutenant Governor in Council; (‘principe de precaution’)”.

I know I did not do justice to that.

**The Chair:** Oh, that was a different language.

**Mr. Fonseca:** My French, yes.

**The Chair:** Okay. Sorry. Do you wish to speak to—

**Mr. Fonseca:** No.

**The Chair:** Any additional? Mr. O’Toole?

**Mr. O’Toole:** If I may, I’m just wondering what this section actually does. Today, it would be the Ministry of Labour that would investigate a work-related incident. It may even have a hearing and an order. Is this going to require the municipality or the regional level of government, upper tier, to investigate work-related accidents and then issue orders?

**Mr. Fonseca:** For Mr. O’Toole, I’ll just let you know that this was the main theme in Justice Campbell’s report on SARS. This is where this is coming from.

I’ll ask for a recorded vote here, Chair.

**The Chair:** Any additional discussion on amendment 10?

**Mr. O’Toole:** Quite frankly, I need to know. You’re saying here that this function of looking at a hospital level—don’t you see the province would have an overarching responsibility to invoke some very high-level orders to require all hospitals to comply in the event of a thing like SARS where they had to utilize all the resources of the province even to figure out what the cause was? If you think that I’m going to accept this based on your downloading it to Dr. Robert Kyle, the medical officer of health for Durham, to have all the resources and the costs to determine labs and all these things—is this what this does?

The medical officer of health is going to say that there is existing or may exist “an outbreak of infectious or communicable disease” or “(b) the proposed directive relates to worker health and safety in the use of any protective clothing, equipment or device.” That’s a provincial responsibility. I guess you’re saying it’s the chief medical officer of health. I just want to be clear that it isn’t the medical officer of health by region; it’s the provincial medical officer of health.

**Mr. Fonseca:** Yes, the chief medical officer of health.

**Mr. O’Toole:** Okay. I get it.

**The Chair:** Okay. Any additional discussion? I will call the vote. There has been a request for a recorded vote.

#### Ayes

Fonseca, Kular, Martel, Milloy, O’Toole, Ramal, Sandals, Witmer.

**The Chair:** The motion is carried.

That brings us to Progressive Conservative motion 11. Mrs. Witmer.

**Mrs. Witmer:** I move that section 77.7 of the Health Protection and Promotion Act, as set out in section 14 of schedule F to the bill, be amended by adding the following subsection:

“Objections to directive

“(2.1) Despite subsection (2), a health care provider or health care entity that is served with a directive may advise the chief medical officer of health of its objections, and may apply for an exemption in whole or in part.”

The government is being given extensive powers without a mechanism of appeal. This is why it’s here.

1650

**The Chair:** Any additional discussion? I will call the vote.

Those in favour of the motion? Those opposed? The motion is lost.

Shall schedule F, section 14, as amended, carry? It is carried.

Schedule F, section 15, moves us to government motion 12.

**Mr. Fonseca:** I move that Section 81.1 of the Health Protection and Promotion Act, as set out in section 15 of schedule F to the bill, be struck out and the following substituted:

“Associate chief medical officer of health

“81.1 (1) The position of associate chief medical officer of health is established.

“Person who shall hold position

“(2) Subject to subsection (3), the position of associate chief medical officer of health shall be held by the person or persons who, by virtue of their position, hold the title of ‘associate chief medical officer of health’ in the ministry.

“Qualifications

“(3) No person is qualified to be or to act as an associate chief medical officer of health unless he or she is a physician of at least five years standing and possesses the qualifications prescribed by the regulations for the position of medical officer of health.

“Functions, duties, etc.

“(4) An associate chief medical officer of health,

“(a) shall perform such functions and duties as the chief medical officer of health may specify in writing; and

“(b) shall act in the place of the chief medical officer of health when the chief medical officer of health is absent or is unable to perform the functions of his or her office or when the office of chief medical officer of health is vacant.

“Regulations

“(5) The minister may make regulations clarifying, modifying or restricting the functions, powers and duties of associate chief medical officers of health.”

**The Chair:** Do you wish to speak to the amendment?

**Mr. Fonseca:** No.

**Ms. Martel:** I'm not sure if Mr. Fonseca can answer them or if we can have some ministry staff. Just for clarification on the regulations section, it's in the plural, so it speaks to the duties of the associate chief medical officers of health. Are we presuming there's going to be more than one?

**Mr. Fonseca:** Yes, it would allow for more than one.

**Ms. Martel:** For the purposes of the rest of the bill, does it have to be clarified that it's in the plural for the rest of the duties and responsibilities that are assigned? Right now, it's in a singular tense.

**The Chair:** I would ask that you state your name before responding.

**Mr. Liam Scott:** Liam Scott, legal counsel with the Ministry of Health.

With respect to other amendments, the only other place in the bill where the associate chief medical officer of health appears is in section 95, which is liability protection, and in that respect we believe that, given the context, we wouldn't need to amend section 95 as well as a result of adding more than one associate chief medical officer of health to be appointed.

**Ms. Martel:** Just for clarification, for the amendment that we're dealing with right now, even though subsection 5 talks about associate medical officers of health, you don't have to have that reflected in the rest of the amendment, in the sections above? It doesn't have to be reflected that you're talking about the potential for more than one?

**Mr. Scott:** It actually does. In subsection 81.1(2), it now says: "...the position of associate chief medical officer of health shall be held by the person or persons who, by virtue of their office...."

**Ms. Martel:** My apologies.

**Mr. Scott:** That's intended to reflect the fact that there could be more than one associate chief medical officer.

**Ms. Martel:** My next question is, how does this person get their position? Are they appointed by the Lieutenant Governor in Council or are they hired by the Ministry of Health?

**Mr. Scott:** Currently, the position of the associate chief medical officer of health is an existing administrative position within the Ministry of Health and Long-Term Care, so it's a bureaucratic appointment.

**Ms. Martel:** So if it already exists, what's the purpose of the amendment?

**Mr. Scott:** The purpose of the amendment is to give the administrative officer of the associate chief medical officer of health, in the absence or the inability of the chief medical officer of health to act—the associate chief currently, before this amendment goes through, cannot exercise any of the chief medical officer of health's statutory powers. By creating this position in statute, it allows, in the event that there is a sudden departure of the chief medical officer of health—if the position suddenly becomes vacant—that there isn't a gap, so to speak, or a need to appoint on an urgent basis an interim chief medical officer of health to allow for the statutory powers to be exercised.

**Ms. Martel:** So what it gets away from is what we have ended up doing as a result of Ms. Basrur's departure. We had to have an order in council by the Legislature to allow Dr. Pasut to take that position. We had to do it by order in council because it was not in the legislation. Is that correct?

**Mr. Scott:** That is correct.

**Ms. Martel:** Okay. My other question: Under "qualifications," where it says "physician of at least five years standing and possesses the qualifications prescribed by the regulations," can you give us some indication of what those would be? I ask that question because right now, Mrs. Witmer and myself are involved in the hiring process for the new chief medical officer of health/ADM for public health. We have, at the request of a number of medical officers of health, put in some specific requirements for that position which I hope would hold for an associate, but all we have here is at least five years' standing and we had some views—in fact, in the ad we go further than that. Can you give the committee some idea of what you're talking about in terms of who would be qualified?

**Mr. Scott:** It is intended to be the same. The reason why there is a reference to the regulations is that it is intended to be the same for the associate chief medical officer of health, the medical officer of health and the chief medical officer of health. Regulation 566, under the Health Protection and Promotion Act, specifies a number of different requirements that must be met by a medical officer of health before assuming that position. I could obtain the regulation and give you more specifics, if that is desirable.

**Ms. Martel:** That would be helpful, so that we can see what that regulation already says in terms of what the expected requirements are of somebody in that position, because we've had to make that clear through the ad.

**Mr. Scott:** I can certainly do that. I'll have to retire for a moment to obtain the regulation to cite for you all of the requirements.

**Ms. Martel:** I'll let you answer Mrs. Witmer's questions first before you do that. Thank you.

**Mrs. Witmer:** Actually, my questions have now been answered. There's only so much in there.

**Mr. O'Toole:** Just to be clear, the only thing that it's really changing is under the section where it's actually adding the phrase "or persons" and it drops an "s" from "holds"?

**Mr. Scott:** Yes.

**Mr. O'Toole:** That's about all it does. Everything else is word for word what the existing section is.

**Mr. Scott:** There is one additional change, the addition of the words "or persons." If you note, in 81.1, clause 4(b), it indicates now, "shall act in the place of the chief medical officer of health when the chief medical officer of health is absent or is unable to perform the functions of his or her office." That change is to be consistent. Previously, the wording simply said, "is absent or when the chief medical officer of health is vacant," which did not cover a situation where you could



have a chief medical officer of health still in office but mentally incapable of making decisions. That change reflects that possibility. So there are two changes in the previous wording of that section.

**The Chair:** Do you still require additional—

**Ms. Martel:** No.

**The Chair:** Is there any other discussion?

**Mr. O'Toole:** Dr. Basrur was the chief medical officer of health and unfortunately became ill and unable. Would this be addressing those circumstances if it came up in the future?

**Mr. Scott:** Yes. If say, the current acting interim chief medical officer of health suddenly became ill or incapacitated, it would mean that the associate chief medical officer of health could exercise the statutory powers of the chief medical officer of health in that urgent type of situation, yes.

**Ms. Martel:** In that case, they're only exercising the power of the chief medical officer of health. You'd continue to have a scenario like we do right now, where someone else is exercising the ADM position. Is that correct? You're talking about an individual who's only replacing one part of that dual role?

**Mr. Scott:** We are only addressing here the statutory powers of the chief medical officer of health. We're not addressing any administrative functions that may exist within the Ministry of Health and Long-Term Care. That's correct.

**The Chair:** I'm going to call the vote.

Those in favour of the motion? Those opposed? The motion is carried.

Shall schedule F, section 15, as amended, carry? It is carried.

Shall schedule F, sections 16 to 24, carry? Carried.

Lastly, because we are now finished schedule F, shall schedule F, as amended, carry? That's carried.

Moving us now to schedule G. Shall schedule G, section 1, carry? Carried.

Moving us now to schedule G, section 2, there's a government amendment, number 13.

1700

**Mr. Kuldeep Kular (Bramalea-Gore-Malton-Springdale):** I move that subsection 5(7) of the Health Insurance Act, as set out in subsection 2(1) of schedule G to the bill, be struck out and the following substituted:

"List

"(7) Immediately upon the coming into force of this subsection, there shall be published on the Internet at a website that is accessible to physicians a list of circumstances described in subsection 18(2) for which payments are subject to correction. The list will initially be established by the medical services payment committee established by agreement between the Ontario Medical Association and the crown in right of Ontario.

"Payment correction list

"(7.1) For greater clarity, a circumstance described in subsection 18(2) may be listed or described on the payment correction list without specific reference to subsection 18(2)."

**The Chair:** Do you wish to speak to the motion? Any discussion?

**Mr. O'Toole:** Yes, I just notice it says, "immediately upon coming into force," so this section must already be ready, because in the previous section, subsection (7), it said, "90 business days after the coming into force of this subsection." So they already have this ready, I guess. Is that it? It's ready to go?

**Mr. Kular:** This is what the—

**Mr. O'Toole:** You're just reading it. I get that; I understand that. Somebody who had actually written it could tell us what that is about.

**Mr. Kular:** This is how the OMA wanted it, so we are amending it according to the OMA.

**The Chair:** Okay. If there's no other discussion, I will call the vote. Those in favour? Opposed? It is carried.

So shall schedule G, section 2, as amended, carry? It's carried.

Now, shall schedule G, sections 3 to 7, carry? Carried.

We are now at schedule G, section 8, and first we have government motion number 14.

**Mr. Kular:** I move that section 8 of schedule G to the bill be amended by adding the following subsection:

"(0.1) Subsection 18(1) of the act is repealed and the following substituted:

"Payment of accounts

"(1) The general manager shall determine all issues relating to accounts for insured services in accordance with this act and shall make the payments from the plan that are authorized under this act."

**The Chair:** Any discussion? There being none, I will call the vote. Those in favour of motion 14? It is carried.

I am now going to call a recess until after the vote. Do you want to continue going?

**Mrs. Witmer:** There are still six minutes left.

**The Chair:** Yes, but you don't walk as slowly as I do. We'll move on, then. I haven't hit the gavel. Technically I'm still okay, but if I'm late for the vote it's on your conscience.

Government motion number 15.

**Mrs. Witmer:** We're not going, so you can stay.

**Mr. O'Toole:** We lose every vote.

**The Chair:** You're going to let them lose without you?

**Mr. Kular:** I move that subsection 18(4) of the Health Insurance Act, as set out in section 8 of schedule G to the bill, be struck out and the following substituted:

"Refusal to pay

"(4) Despite subsection (2), the general manager may refuse to pay a physician for a service or pay a reduced amount for the service only if a circumstance described in subsection (2) that is also set out or described in the payment correction list exists in respect of the claim or claims, or if permitted to do so by an order of the review board.

"Referral to review board for expedited hearing

"(4.1) Where the general manager is of the opinion that for a claim or claims submitted for insured services rendered by a physician, a circumstance described in

subsection (2) that is not also set out or described in the payment correction list exists in respect of the claim or claims, and is of the opinion that the physician knew or ought to have known that the claim or claims were false, the general manager may give a notice to the review board requesting it to hold an expedited hearing.

“Expedited hearing, notice

“(4.2) The general manager may request an expedited hearing without notice to the physician, but shall promptly afterwards give notice to the physician.”

**The Chair:** Any discussion?

**Mr. O’Toole:** Could you give us an example of where there’s a dispute? This is a process for refusal to pay from the board and the doctor. There could be an expedited hearing without notice, deemed in the opinion of the general manager that they ought to have known, and so he’ll just be told, “You’re not getting paid for that service.” It says here “without notice ... an expedited hearing.” The next day they have a hearing, they decide he ought to have known about certain circumstances and they refuse to pay him.

**The Chair:** We will respond to that after the recess. The committee is now in recess.

*The committee recessed from 1706 to 1716.*

**The Chair:** The committee is back in session. When we left, Mr. O’Toole had asked a question. Mr. Kular.

**Mr. Kular:** The government believes most of the physicians are honest professionals. This amendment came through our discussions with the Ontario Medical Association. Definitely the physician will receive notice after a hearing has been requested.

**The Chair:** Any other discussion? We have amendment 15 on the floor. Those in favour? Opposed? It is carried.

That moves us to government motion 16.

**Mr. Kular:** I move that subsections 18(8) and (9) of the Health Insurance Act, as set out in section 8 of schedule G to the bill, be struck out and the following substituted:

“Notice, physician, refusal to pay or reduced payment

“(8) The general manager shall give notice to a physician of a decision to refuse to pay for a service or to pay a reduced amount because a circumstance described in subsection (2) that is set out or described in the payment correction list exists in respect of the claim or claims.

“Notice, physician, re payment correction list after payment

“(9) Despite subsections (12) to (16), if the general manager is of the opinion that an amount paid to a physician for a service should not have been paid or should have been paid at a reduced amount because a circumstance described in subsection (2) that is set out or described in the payment correction list exists in respect of the claim or claims, the general manager may give notice to the physician of the circumstance and of the amount the general manager believes is owing.”

**The Chair:** Any discussion? Those in favour of the motion? Opposed? It is carried.

That brings us now to government motion 17.

**Mr. Kular:** I move that subsection 18(16) of the Health Insurance Act, as set out in section 8 of schedule G to the bill, be struck out and the following substituted:

“Immediate referral for false claims by physician

“(16) Despite subsection (15), the general manager may give a notice to the review board requesting it to hold a hearing without giving a notice to the physician under subsection (13), but shall promptly afterwards give notice to the physician of the request for a hearing, if the general manager is of the opinion that a circumstance described in subsection (2) exists in respect of one or more claims paid for services provided by the physician, and that the physician knew or ought to have known that the claims submitted to the plan were false.”

**The Chair:** Discussion? Hearing none, I’ll call the vote. Those in favour of the motion? Opposed? It is carried.

Shall schedule G, section 8, as amended, carry? That’s carried.

We’re moving now to schedule G, section 9, government motion 18.

**Mr. Kular:** I move that section 9 of schedule G to the bill be struck out and the following substituted:

“9. Section 18.0.1 of the act is repealed and the following substituted:

“Physicians

“18.0.1(1) During the period that commences when section 9 of schedule G to the Health System Improvements Act, 2007 comes into force and ends when this section is repealed, this section applies with respect to requests for review by the review board made by physicians and the general manager.

“Panel review

“(2) Subject to the other provisions of this section, on the request of a physician pursuant to subsections 18(11) or (14) or the general manager pursuant to subsection 18(4.1), (15) or (16), the transitional physician audit panel shall, in accordance with this section, conduct any review that would be conducted by the review board under this act if this section were not in force.

“If review requested

“(3) If a physician or the general manager requests a review under subsection (2), the chair of the appeal board shall designate members of the transitional physician audit panel to deal with the review and set a time for the review and the panel shall conduct the review and render its direction as expeditiously as may be reasonably possible, and in any case shall render its direction no more than 45 days after the last day on which evidence in the review was adduced before the panel, unless the general manager and the physician consent to an extension.

“Parties

“(4) Only the general manager and the physician are parties to a review by the transitional physician audit panel.

“Directions

“(5) Following the review, the transitional physician audit panel may give any of the following directions:



"1. That the decision or opinion of the general manager be confirmed.

"2. That the general manager make a payment in accordance with the submitted account.

"3. That the general manager pay a reduced amount, as calculated by the general manager in accordance with the direction.

"4. That the physician reimburse the plan in the amount calculated by the general manager in accordance with the direction.

"Interest, payable by physician

"(6) If, as a result of a direction by the transitional physician audit panel, an amount is payable by a physician, interest calculated in the prescribed manner is payable on the amount, payable from the date the account was paid by the plan.

"Interest, payable to physician

"(7) If, as a result of a direction by the transitional physician audit panel, an amount is payable by the general manager, interest calculated in the prescribed manner is payable on the amount, payable from the date the amount was recovered from the physician by the plan.

"Applicability of certain provisions

"(8) The following provisions apply, with necessary modifications, to a review by the transitional physician audit panel:

"1. Subsection 21(2).

"2. Subsections 23(1) to (4) and (6).

"3. Subsection 27.2(1).

"Appeal to Divisional Court.

"(9) Any party to a review before the transitional physician audit panel may appeal from the panel's direction to the Divisional Court in accordance with the rules of the court, but,

"(a) personal health information contained in any document or evidence filed or adduced with regard to the appeal, or in any order or decision of the court, shall not be made accessible to the public; and

"(b) the Divisional Court may edit any documents it releases to the public to remove any personal health information."

**The Chair:** Any discussion?

**Mr. O'Toole:** It's a fairly lengthy amendment to what was otherwise reduced to a couple of black lines in the book. I'm just going to ask a general question: Is this in response to the MRC, the Medical Review Commission, which had undergone quite a few questions in terms of the review of practice brought on by the Cory report and a few other things. There was a lot of outrage. So I ask, is this in response to that process?

**Mr. Kular:** Yes, it's a response to the auditing process. That's why this amendment—

**Mr. O'Toole:** A lot of this stuff here is just going to be done—in this case, there's a section where there are 45 days from the last adducing of evidence. Is everybody going to be happy with this? I'm taking it on you that you've consulted with the OMA, they gave you the amendment, and you're reading it.

**Mr. Kular:** Yes. We had discussions with the Ontario Medical Association, and that's why we are bringing these amendments.

**Mr. O'Toole:** So they're happy with it, and I can send them all a letter in my riding and say, "Your problems are solved"?

*Interjection.*

**Mr. O'Toole:** Thank you.

**The Chair:** You might even want to take credit for it.

**Mr. O'Toole:** I'm always there to defend my constituents, is how I put it. They're professionals. I sent copies of Bill 171. They were surprised and delighted that I'd asked.

**Mr. Ramal:** We're trying to help, here; we're trying to help you out.

**Mr. O'Toole:** I'm a trusting person.

**The Chair:** Hearing no other discussion, I would call the vote. Those in favour of the amendment? Opposed? It is carried.

Shall schedule G, section 9, as amended, carry? Carried.

Shall schedule G, section 10, carry? Carried.

Moving now to schedule G, section 11, we have government motion 19.

**Mr. Kular:** I move that subsection 18.0.6(3) of the Health Insurance Act, as set out in subsection 11(3) of schedule G to the bill, be struck out and the following substituted:

"Same

"(3) If, during the time that section 18.0.1 was in force, a physician had requested a review by the transitional physician audit panel under subsection 18.0.1(3), as it read before section 9 of schedule G to the Health System Improvements Act, 2007 came into force, and where at the time this subsection comes into force there has been no agreement between the physician and the general manager with respect to the matter, the decision of the general manager referred to in subsection 18.0.1(3) is deemed to be withdrawn and the general manager is authorized to reimburse any amounts recovered plus interest, if applicable."

**The Chair:** Discussion? Those in favour of the amendment? Opposed? Carried.

Shall schedule G, section 11, as amended, carry? It is carried.

Moving now to schedule G, section 12, government motion 20.

**Mr. Kular:** I move that section 18.0.7 of the Health Insurance Act, as set out in section 12 of schedule G to the bill, be amended by adding the following subsection:

"Same

"(2) Where, during the time that section 18.0.1 was in force, the transitional physician audit panel commenced a review, it has the authority to complete the review and issue a direction in accordance with that section."

**The Chair:** Any discussion? I call the question. Those in favour of the motion? Opposed? It is carried.

I will now ask: Shall schedule G, section 12, as amended, carry? It is carried.

I will now ask: Shall schedule G, sections 13 to 32, carry? Carried.

That moves us to schedule G, section 33, and there is a government amendment: 21.

**Mr. Kular:** I move that section 33 of schedule G to the bill be amended by adding the following subsection:

“(5) Section 45 of the act is amended by adding the following subsection:

““Consultation

“(1.3) The Lieutenant Governor in Council shall not make a regulation providing for additional requirements that physicians must comply with in maintaining records under clause 37.1(4.1)(b) unless the minister has first consulted either or both of the following:

““1. The payment committee.

““2. The medical services payment committee established by agreement between the Ontario Medical Association and the crown in right of Ontario.”

**The Chair:** Discussion? I call the vote. Those in favour of the motion? Opposed? It is carried.

Shall schedule G, section 33, as amended, carry? It is carried.

Now we're at schedule G, section 34, starting with government motion 22.

**Mr. Kular:** I move that schedule 1 to the Health Insurance Act, as set out in section 34 of schedule G to the bill, be amended by adding the following section:

“Expedited hearings

“3.1(1) When the review board has received a request for an expedited hearing under subsection 18(4.1) of the act, the chair of the review board or, in his or her absence, a vice-chair shall promptly select a panel to deal with the request, and the panel shall hear the matter and make an order as expeditiously as possible or, if a time has been prescribed, within that time.

“Same

“(2) The review board may make rules respecting the holding of expedited hearings.”

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**The Chair:** Any discussion? All those in favour? Opposed? Carried.

Government motion 23.

**Mr. Kular:** I move that subsection 10(1) of schedule 1 to the Health Insurance Act, as set out in section 34 of schedule G to the bill, be amended by adding the following paragraph:

“2.1 Where the physician has breached a previous order of the review board, an order that the general manager refuse to pay, or pay a reduced amount as determined by the review panel, with respect to identical future claims submitted during a time period determined by the review panel.”

**The Chair:** Discussion? Those in favour of the motion? Opposed? Carried.

Government motion 24.

**Mr. Kular:** I move that paragraph 4 of subsection 10(1) of schedule 1 to the Health Insurance Act, as set out in section 34 of schedule G to the bill, be struck out and the following substituted:

“4. An order that, despite subsections 4(1) and (2), the period of review for reimbursement be for a period of more than 12 months, or that the period of review for reimbursement be for a period commencing prior to the date provided for in subsection 4(2), or both, where the review panel determines that the physician knew or ought to have known that claims submitted to the plan or to an insured person were false.”

**The Chair:** Discussion? Those in favour of the motion? Opposed? It is carried.

Government motion 25.

**Mr. Kular:** I move that subsection 10(2) of schedule 1 to the Health Insurance Act, as set out in section 34 of schedule G to the bill, be struck out and the following substituted:

“Additional orders

“(2) The general manager may enter in evidence before the review panel a random sample of claims submitted by the physician to the plan in respect of a fee code during the period of review and, in addition to any other order it may make, the review panel may order that the general manager calculate the amount to be reimbursed for that fee code for that period, or a portion of that period, by assuming the results observed in the random sample are representative of all the claims during the period in question, where the review panel determines that,

“(a) the physician is liable to reimburse the plan;

“(b) there has been a previous finding or order by a review panel that the physician reimburse the plan and the physician has continued to make billing errors despite documented efforts to educate the physician regarding billing requirements; and

“(c) the sample was random and had a reasonable confidence interval.”

**The Chair:** Any discussion? Those in favour? Those opposed? It is carried.

Government motion 26.

**Mr. Kular:** I move that subsection 10(5) of schedule 1 to the Health Insurance Act, as set out in section 34 of schedule G to the bill, be struck out and the following substituted:

“Suspension

“(5) An order under paragraph 5 of subsection (1) shall not be made unless the review panel finds that the physician knew or ought to have known that the claims submitted to the plan or to insured persons were false.”

**The Chair:** Discussion? Those in favour? Opposed? Carried.

Government motion 27.

**Mr. Kular:** I move that subsections 11(5) and (6) of schedule 1 to the Health Insurance Act, as set out in section 34 of schedule G to the bill, be struck out and the following substituted:

“Lift of stay

“(5) Despite the Statutory Powers Procedure Act or any other act, within 30 days of the physician filing an appeal to the Divisional Court under this section, the general manager may bring a motion to the Divisional



Court requesting it to lift the stay of an order made under paragraph 5 of subsection 10(1) and the Divisional Court may order that the stay be lifted.”

**The Chair:** Discussion? Those in favour of the motion? Opposed? It is carried.

I will ask the question: Shall schedule G, section 34, as amended, carry? Carried.

**Mr. O'Toole:** Mr. Chair, if I may make a comment. With so many amendments to that one section, in such an important area, I think it does demonstrate our caution and concern with this omnibus bill. I just want to put it on the record because I read along with them and I read every page. I still remain concerned when there are so many errors in drafting that—take your time and get it right. This is the health care system of Ontario that's in jeopardy here.

**The Chair:** Okay. I'm going to ask, schedule G, sections 35 and 36: Shall they carry? Carried.

Shall schedule G, as amended, carry? Carried.

Shall schedule H, section 1, carry? Carried.

Schedule H, section 2: We have government amendment number 28—moved by Mr. Fonseca?

**Mr. Fonseca:** Yes. I move that subsection 2(2) of schedule H to the bill be struck out.

**The Chair:** Discussion? I will call the question. Those in favour? Opposed? It is carried.

Shall schedule H, section 2, as amended, carry? Carried.

I will now ask, shall schedule H, sections 3 to 23, carry? They are carried.

I will now ask, shall schedule H, as amended, carry? It is carried.

That brings us to schedule I. We have NDP motion number 28.1. Ms. Martel.

**Ms. Martel:** Legislative counsel is going to tell me if I need to ask for unanimous consent here. Yes? No?

**The Chair:** This amendment is in order.

**Ms. Martel:** Thank you so much, Chair; thank you, Ralph.

I move that schedule I to the bill be amended by adding the following section:

“0.1 The Public Hospitals Act is amended by adding the following section:

“Ombudsman

“3.1 The Ombudsman shall have oversight over public hospitals.”

When I sat on the Bill 140 committee hearings, which are changing the Long-Term Care Homes Act, as a result of what we heard during the course of the public hearings, I moved an amendment at that time to extend oversight of long-term care to the current Ombudsman. We heard during the course of those public hearings concern generally about the Ombudsman having oversight over other health sectors as well. Clearly, I believe that the Ombudsman should have final oversight over Ontario hospitals so that patients and their families have an independent body to go to in order to get their concerns dealt with when they feel that these are not being dealt

with by the hospital, by the CEO of the hospital or by the board of the hospital.

The Ontario Society of Senior Citizens' Organizations in particular during Bill 140 was very supportive of a broader oversight mandate for the Ombudsman, including other health sectors like hospitals. It's in that context, in terms of their concerns and in terms of ensuring that there is some independent oversight, somewhere to go at the end of the day when you can't get your concerns dealt with by the hospital or hospital board, that the current Ombudsman would then have the authority to investigate complaints and essentially make orders to the government about what changes have to occur.

**The Chair:** Any discussion?

**Mr. Fonseca:** I have to say that our government's record in terms of transparency and opening up institutions that are publicly funded like hospitals—unlike some previous governments, we've allowed the Provincial Auditor to now go into the hospitals. In his report, I was able to find some of the errors that were happening when it came to CT scans and other procedures that are taking place in hospitals.

**The Chair:** Ms. Martel?

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**Ms. Martel:** Chair, if I might, I don't see the similarity at all with respect to the work of the Ombudsman or the Auditor General. In fact, the work that they do is quite different. The Auditor General can conduct value-for-money audits of public hospitals and broader public institutions in the MUSH sector.

We are talking about the Ombudsman and his or her role under the Ombudsman Act of investigating complaints from individuals who believe the system is failing them, or for dealing with systemic barriers, problems, concerns or complaints within a particular system; in this case, in the hospital system. So it is irrelevant, frankly, to offer up the additional role of the Auditor General as a response or defence to allowing the Ombudsman to investigate complaints. The two have completely different roles. We should be supporting more independence, just as we supported more independence in the role of the Auditor General.

So this allows the Ombudsman, who has a staff that investigates complaints, to expand his authority, to expand his role in terms of dealing with complaints and systemic barriers that occur in the hospital system. It has nothing to do with value-for-money audits.

**Mr. O'Toole:** Ms. Martel makes a point. I'd like to see a bit more fairness in health care. At Lakeridge Health in Durham region, where I try to represent people, they were directed by the Ministry of Health to actually cut services. I have the memo from George—Minister Smitherman, pardon me—furious George. The GTA/905 survey clearly demonstrates, scientifically and objectively, that they are short over \$200 per person in our hospitals.

Mr. Fonseca, you mentioned in your opening remarks that you pride yourself as a government on transparency and openness. I read an article in the paper today by Ian

Urquhart on the responses from the Minister of Citizenship and Immigration on this openness and transparency. Let's put the record straight. We haven't had an answer for two weeks, and now you're saying, "Trust me." I don't know. I need to get that on the record because I want every citizen of Ontario to at least get their fair share of funding, and whether it's enough or not is an order of cabinet and an order of the economy, I suppose. Anyway, that's how I feel about it—strongly.

**Ms. Martel:** Recorded vote.

**Mrs. Witmer:** Mr. Chair, I have a question. I personally don't believe that this is the appropriate place to be making this type of decision. I would be voting against this particular amendment.

**The Chair:** No other discussion? I will call the vote.

### Ayes

Martel.

### Nays

Fonseca, Kular, Milloy, Ramal, Sandals, Witmer.

**The Chair:** The motion is lost.

I will now ask, shall schedule I, section 1, carry?

*Interjection.*

**The Chair:** I'm going to rephrase that. Shall schedule I, sections 2 to 4, carry? Carried.

Shall schedule I carry? Carried.

Shall schedule J, sections 1 to 6, carry? Carried.

Shall schedule J carry? Carried.

Schedule K, section 1: We have first NDP motion number 29.

**Ms. Martel:** I move that section 1 of schedule K to the bill be struck out and the following substituted:

"Purpose

"1. The purpose of this act is to enhance the protection and promotion of the health of Ontarians and reduce health inequities through the establishment of an agency to provide scientific and technical advice and support to those working across sectors to protect and improve the health of Ontarians and to carry out and support activities such as population health assessment, public health research, surveillance, epidemiology, planning, and evaluation."

**The Chair:** Do you wish to speak to the motion?

**Ms. Martel:** Yes, I would, actually. The wording that I have used in this purpose clause is the exact wording that was provided to the committee by the Registered Nurses Association of Ontario in its proposed amendments and proposed changes. I understand that the government is going to move a friendly amendment to my amendment, and I would point out that the government's friendly amendment changes five—note, five—words from my amendment to theirs. The five words do not change the spirit or the intent at all of the motion that I put forward. So I think it's a little silly that at this point the government has to move five words in order to have

an amendment that comes from the government versus an amendment that is accepted by an opposition member.

**The Chair:** Any other discussion?

**Mr. Fonseca:** If I could clarify, Chair, this wording change is that the agency can't be ultimately responsible and contribute to the efforts that reduce health inequities.

**The Chair:** You're speaking about a motion that you've not moved.

**Mr. Fonseca:** Yes, I'm speaking to a comment that Ms. Martel made in regard to a government motion that I am going to move now, that I'd like to bring forward. Would you like me to read it into the record?

**Ms. Martel:** Well, before you do that, since it's started, let me just read the two sections. Here's my amendment. It says: "The purpose of this act is to enhance the protection and promotion of the health of Ontarians and reduce health inequities...." Here's the government's proposal that's coming next: "The purpose of this act is to enhance the protection and promotion of the health of Ontarians and"—this is the new section—"to contribute to efforts to reduce health inequities...." That's how silly this is.

**Mr. Fonseca:** It just would not hold the agency ultimately responsible. That's what that would do.

**Ms. Martel:** Peter, come on. This is so sad. It's silly.

**The Chair:** Okay. Just from a procedural viewpoint, you're debating an amendment to an amendment that has not yet been moved. You need to move it before we debate it.

**Mr. Fonseca:** Okay, I will move this. I move that Ms. Martel's motion concerning section 1 of schedule K to the bill be amended to read as follows:

I move that section 1 of schedule K to the bill be struck out and the following substituted:

"Purpose

"1. The purpose of this act is to enhance the protection and promotion of the health of Ontarians and to contribute to efforts to reduce health inequities through the establishment of an agency to provide scientific and technical advice and support to those working across sectors to protect and improve the health of Ontarians and to carry out and support activities such as population health assessment, public health research, surveillance, epidemiology, planning and evaluation."

**The Chair:** Is there now any additional discussion on the amendment to the amendment?

**Mrs. Witmer:** Well, this does seem a little bit silly, the addition of these five words. I'd really appreciate if the legal folks at the Ministry of Health would tell us why this change in those words, which seem rather insignificant, is necessary and why we couldn't just accept Ms. Martel's motion.

**The Chair:** If you would state your name, please.

**Ms. Paula Kashul:** Paula Kashul, legal counsel, Ministry of Health and Long-Term Care. I believe the question was—

**Mrs. Witmer:** The question was that it appears that Ms. Martel had a motion which certainly, if you take a look at it, would appropriately address the issue, and the government has now introduced an amendment that has



added five words—"to contribute to efforts to"—and I'm not sure why that would be necessary and why we couldn't support Ms. Martel's motion.

**Ms. Kashul:** My understanding of the change is that the agency itself is only one player, so the words have been added to reflect that—only one player in the health care system in terms of action and directing action. In fact, the agency is primarily a research organization.

**The Chair:** Any additional discussion?

**Ms. Martel:** If I might, Chair, it has nothing to do with players. God, my words say "reduce health inequities"; the government's say "to contribute to efforts to reduce health inequities." There's no mention of players or anything like that. I'm not disputing legal counsel; you may have been told you had to do that. I just think it's really silly that we're in this position just to make sure we can't accept an opposition amendment, honestly.

**Mr. O'Toole:** Well, I personally see it as an aberration. It's changing substantively the direction of Ms. Martel. It says to "reduce health inequities." That's a very specific direction. The other one says "to contribute to efforts to reduce." It avoids any responsibility for health promotion and protection, as they see it. Do you see? It becomes fuzzy and vague. I mean, you're trained in legal language. This is an example of what the treach-

ery of words does. One is very specific: "Reduce health inequities." It's very specific. This one here says, "Contribute to efforts to reduce." It's sort of soft—it's Liberal language. I hate to be so partisan here, but it turns out that's my job.

Hey, look, you've changed the whole thing. It's sort of like apples and oranges here. This is a purpose clause which sets out in broader terms the intent of that particular schedule K.

**The Chair:** I'm conscious of the time.

**Mr. O'Toole:** Thank you very much for that.

**The Chair:** I would now ask the question on the amendment to the amendment. Those in favour? Opposed? The amendment to the amendment is carried.

We will now vote on the original motion, as amended. Those in favour? Those opposed? It is carried.

I will now adjourn this committee until tomorrow afternoon, when we meet to consider further amendments.

**Mrs. Witmer:** And then next week?

**The Chair:** If we don't finish, then it's next week. We are adjourned.

*The committee adjourned at 1752.*

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Ministry of Health and Long-Term Care

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## Assemblée législative de l'Ontario

Deuxième session, 38<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 8 May 2007

# Journal des débats (Hansard)

Mardi 8 mai 2007

## Standing committee on social policy

Health System  
Improvements Act, 2007

## Comité permanent de la politique sociale

Loi de 2007 sur l'amélioration  
du système de santé



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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Tuesday 8 May 2007

Mardi 8 mai 2007

*The committee met at 1621 in committee room 1.*HEALTH SYSTEM  
IMPROVEMENTS ACT, 2007LOI DE 2007 SUR L'AMÉLIORATION  
DU SYSTÈME DE SANTÉ

Consideration of Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts / Projet de loi 171, Loi visant à améliorer les systèmes de santé en modifiant ou en abrogeant divers textes de loi et en édictant certaines lois.

**The Chair (Mr. Ernie Parsons):** I would like to call to order the meeting of the standing committee on social policy, where we will continue clause-by-clause deliberation on Bill 171.

When last we met, we had just finished voting on amendment number 29. This moves us to amendment number 30, which is an NDP motion.

**Ms. Shelley Martel (Nickel Belt):** I move that section 1 of schedule K to the bill be amended by adding the following subsection:

"Precautionary principle

"(2) This act shall be interpreted in light of the principle that public health action should not wait for scientific certainty."

Chair, if I might, this amendment was put to us by both the Ontario Nurses' Association and the Registered Nurses Association of Ontario in light of the recommendations that were made by the late Justice Campbell in his final report of December 2006. There are a number of amendments that I've put forward to reflect his recommendations, and this is one of them, which is supported by both of those organizations.

**The Chair:** Any other discussion?

**Mr. Peter Fonseca (Mississauga East):** In the final report that was put forward by the agency implementation task force, they felt that this was not a good thing. That's why we will not be supporting it.

**Ms. Martel:** I'm going to go with the late Justice Campbell, and I'd ask for a recorded vote, please.

**The Chair:** If there's no other discussion, I will call the vote.

Ayes

Martel, Witmer.

Nays

Fonseca, Kular, Matthews, Ramal.

**The Chair:** The motion is lost.

I will now ask the question: Shall schedule K, section 1, as amended, carry? It is carried.

Shall schedule K, section 2, carry? Carried.

We're now at schedule K, section 3, NDP amendment number 31.

**Ms. Martel:** I move that section 3 of schedule K to the bill be amended by adding the following subsection:

"Part of public service

"(2) The corporation shall be part of the public service of Ontario, and shall be under the authority of the chief medical officer of health, in his or her capacity as an assistant deputy minister within the Ministry of Health and Long-Term Care."

**The Chair:** Do you wish to speak to it?

**Ms. Martel:** Yes, I do. It's going to take me a few minutes to do that. I would like to read into the record some of what Justice Campbell had to say in the final report on SARS. I should point out that I also mentioned this in the debate on second reading. I was a bit unhappy to note that when Cancer Care Ontario came before us and made the presentation regarding their view of the governance structure of the new agency, they did not reference the final report of the late Chief Justice Archie Campbell. So I want to put on the record what he did say with respect to the governance of the new public health agency, because I think it's quite important to see that his view was quite a bit different than the view that was finally reached by the implementation committee.

This is from his final report in December 2006. It reads as follows with respect to the Ontario Agency for Health Protection and Promotion and the chief medical officer of health: "Although there is much wisdom in the proposal for an Ontario Agency for Health Protection and Promotion, the recommended structure fails to take into account the major SARS problem of divided authority and accountability." That is the very structure that is currently before us in Bill 171, which he had very many concerns about.

"As the commission noted in its second interim report:

"... the SARS response was also hamstrung by an unwieldy emergency leadership structure with no one clearly in charge. A de facto arrangement whereby the chief medical officer of health of the day shared authority

with the commissioner of public safety and security resulted in a lack of clarity as to their respective roles which contributed to hindering the SARS response.'

"An important lesson from SARS is that the last thing Ontario needs, in planning for the next outbreak and to deal with it when it happens, is another major independent player on the block.

"The first report of the agency implementation task force said:

"A body at arm's-length from the government was recommended in the Walker, Campbell and Naylor reports, was a commitment in Operation Health Protection and aligns with the successful experience of the INSPQ" in Quebec.

"The commission in fact recommended a much different arrangement in its first interim report, and warned against creating another 'silo,' another autonomous body, when SARS demonstrated the dangers of such uncoordinated entities:

"First, the structure of the new agency or centre, which will combine advisory and operational functions, must reflect the appropriate balance between independence and accountability whether it is established as a crown corporation or some other form of agency insulated from direct ministerial control.

"Second, it should be an adjunct to the work of the chief medical officer of health and the local medical officers of health, not a competing body. SARS showed that there are already enough autonomous players on the block who can get in each other's way if not properly coordinated. There is always a danger in introducing a semi-autonomous body into a system like public health that is accountable to the public through the government. The risk is that such a body can take on a life of its own and an ivory tower agenda of its own that does not necessarily serve the public interest it was designed to support.'

"Consequently, the commission recommended that the chief medical officer of health have a hands-on role at the agency, including a seat on the board.

"The agency implementation task force took a completely opposite approach, recommending against giving the chief medical officer of health a seat as a voting member of the board, and recommending a very autonomous role for the agency.

"This proposed arrangement ignores important lessons from SARS.

"The commission, far from recommending a completely arm's-length organization, pointed out the need for the chief medical officer of health to be in charge with the assistance of the agency, which should, albeit with a measure of policy independence, be operationally accountable to the chief medical officer of health.

"The commission"—that is Justice Campbell's commission—"therefore recommends:

"—that the government reconsider in light of the lessons of SARS the agency implementation task force's recommendation regarding the relationship between the chief medical officer of health and the agency."

This came out, as I said, in December 2006. It is clear that the government has gone with the governance structure that has been recommended by the agency implementation task force, contrary to recommendations which were made as late as December 2006 by the late Chief Justice Archie Campbell. I am moving this motion because I agree with the recommendations that were made by the late Chief Justice, recommendations that have been given to us specifically by the Ontario public service union and also by the late Chief Justice himself. So I would hope that the government would reconsider the proposed governance structure in light of what Archie Campbell had to say in his final report on SARS.

**The Chair:** Any other discussion?

**Mr. Fonseca:** We would accept this amendment with some changes to it, so what we would like to do is—I think Ms. Martel saw some of the changes yesterday that we had put forward, but we will also have the amendment that we would be proposing, which would be Ms. Martel's amendment. But if she's willing to accept these changes, we would—

*Interjection.*

**Mr. Fonseca:** Oh, page 31; sorry.

**Ms. Martel:** Right now the changes I have are to the next amendment, not this amendment.

**Mr. Fonseca:** Well, that would be the next one.

**Ms. Martel:** But if you want to put forward some changes and support mine, I'm prepared to negotiate with you.

**Mr. Fonseca:** Not on this one; the next one.

**The Chair:** So there is no amendment to this amendment?

**Mr. Fonseca:** No.

**Ms. Martel:** Then I need a recorded vote, please, Chair.

**The Chair:** Okay, I will call the vote.

## Ayes

Martel.

## Nays

Fonseca, Kular, Matthews, Ramal.

**The Chair:** The motion is lost.

Shall schedule K, section 3, carry? Carried.

Shall schedule K, sections 4 and 5, carry? Carried.

This brings us to schedule K, section 6. We have NDP amendment number 32.

1630

**Ms. Martel:** Sorry, Chair. Can you just give us a second? I'm just seeing this for the first time.

*Interjections.*

**Ms. Martel:** Chair, I'm going to need your advice on something. I have my amendment, 32, we have a government amendment, and a new amendment from the government that I'm seeing now that will make changes to my amendment and that is a little bit different from the



one the government proposed yesterday in the new 32. So what do you want me to do?

*Interjections.*

**The Chair:** We're not going quite as fast as I'd hoped.

**Mr. John O'Toole (Durham):** Mr. Chair, if I may, while we're waiting, I just want to put a couple of things on the record. Yesterday, there were two amendments proposed. In the case of Mrs. Witmer, there was an amendment proposed for a section, and then there was a subsequent amendment to that amendment proposed by the government side. In fact, the amendment to the amendment was out of order, in my view, and I'm asking you, through leg. counsel or all these people who get paid the big bucks, when an amendment substantively changes the intent of the original motion—it can be moved as a separate amendment. You can defeat the one amendment and move your own amendment, but that's the process. An amendment cannot substantively change the intent or direction of the original motion. It can change some nuance.

I put that to you and I'd like a legal answer as to whether or not I'm on the right track, because it appears that what's happening is that rather than allow the opposition to participate fully, they're trying to mitigate the poor drafting and the scope of this omnibus bill, such that you've nullified any valid consideration by Mrs. Witmer, a former Minister of Health, who knows many of the stakeholder issues. If the process is what I think it is—

**Mrs. Elizabeth Witmer (Kitchener–Waterloo):** It's a farce.

**Mr. O'Toole:** —a farce, I am seriously concerned about the intention of the government. Why are you forcing such a fundamentally important thing in health care when some of the stakeholders are very upset by, first, the late notice, the rushed transaction, the conglomeration and confusion of amendments and drafting? We had one whole section yesterday on the Medical Review Committee completely amended—the MRC process, which has been the subject of a court inquiry.

I could go on. I think this process is somewhat artificial. For the public listening and those stakeholders whose lives and professions are irrevocably altered by this bill—sometimes for the good, because we're not in any objection to improving the delivery and efficiency of health care; we're not against that at all. But when you start tampering with long-established professions, merging homeopathy, for instance, and naturopathy—it's my understanding that the marriage doesn't work.

I'm subordinate to Mrs. Witmer and Ms. Martel, who have been working on health files for a long time, longer than everyone on that side put together. And no discredit to the efforts that you're making; that's not my point. Then I see amendments that are really, quite frankly, out of order—

**The Chair:** With due respect, when you started your dialogue, Ms. Martel had the floor.

**Mr. O'Toole:** Well, thank you, Ms. Martel. She was getting an amendment to her amendment straightened out.

**The Chair:** I'm going to return the floor to Ms. Martel.

**Ms. Martel:** Thank you, Chair. I think we have this sorted out. I'm going to be moving the new motion 32, which reads as follows.

I move that clauses 6(a) to (f) of schedule K to the bill be struck out and the following substituted:

“(a) to provide scientific and technical advice and support to the health care system and the government of Ontario in order to protect and promote the health of Ontarians and reduce health inequities;

“(b) to develop, disseminate and advance public health knowledge, best practices, and research in the areas of population health assessment, infectious diseases, health promotion, chronic diseases, injury prevention, and environmental health;

“(c) to inform and contribute to policy development processes across sectors of the health care system and within the government of Ontario through advice and impact analysis of public health issues;

“(d) to develop, collect, use, analyze and disclose data, including population health, surveillance and epidemiological data, across sectors, including human health, environmental, animal, agricultural, education, community and social services, and housing sectors, in a manner that informs and enhances healthy public policy and public health planning, evaluation and action;

“(e) to undertake, promote and coordinate public health research in co-operation with academic and research experts as well as the community;

“(f) to provide education and professional development for public health professionals, scientists, researchers, and policy-makers across sectors;”

The original amendment that I moved was wording that was given to me by the Registered Nurses Association, so that was what was put forward. The government motion had some changes, and the motion that has now been read has essentially the language that was given to both of us by RNAO. So I can accept that.

**The Chair:** There's not going to be an amendment. You've accepted that as a friendly amendment, so we have the one motion.

Any additional debate? Hearing none, I will call the vote on an amendment that, for all intents and purposes, I'm going to call 32r, because it replaces the 32 from yesterday. All those in favour? Opposed? It is carried.

That brings us to NDP motion number 33.

**Ms. Martel:** I move that section 6 of schedule K to the bill be amended by adding the following clauses:

“(g.1) to serve as a model for bridging the areas of infection control and occupational health and safety;

“(g.2) to undertake research related to evaluating the modes of transmission of febrile respiratory illnesses and the risk to health workers;”

This is an amendment that was provided by, I believe, the Ontario Nurses' Association and OPSEU as part of the recommendations that came from Justice Campbell's report. We were looking for ways to incorporate what he said in terms of what he felt the model of the new agency

should have as a mandate, and this is a reflection of those amendments from those two organizations.

**The Chair:** Do you support it? Okay. Any additional debate?

*Interjection.*

**The Chair:** A little technical clarification: When you read the motion, the last word you said was “workers.” I think you intended it to be “worker.”

**Ms. Martel:** No, I think it should be “workers.”

1640

**The Chair:** “Workers”? Okay.

**Mr. Ralph Armstrong:** Sorry.

**Ms. Martel:** It’s okay, Ralph. You had a lot to do. Don’t worry about it.

It should be “workers.”

**The Chair:** So, for everyone, the final word is plural; it is “workers” in the amendment. That’s not an amendment to the amendment; that’s a typographical error.

Those in favour of NDP motion number 33? Opposed? It is carried.

Shall schedule K, section 6, as amended, carry? Carried.

Shall schedule K, sections 7 and 8, carry? Carried.

Moving us now to schedule K, section 9, and we have NDP motion number 34.

**Ms. Martel:** I move that subsection 9(2) of schedule K to the bill be amended by adding the following clause:

“(b.1) representatives of labour;”

This was an amendment that was presented to me by the Ontario Nurses’ Association, again as a result of some of what they took to be the important results that came out of the late Justice Campbell’s recommendations around the new agency, what it should look like and its mandate. This makes it clear that there will be a representative of labour on the board of the agency.

**The Chair:** Any other debate?

**Mr. Fonseca:** It’s just inconsistent with the report that was brought forward by the agency implementation task force, so we will not be supporting this.

**Ms. Martel:** It is consistent with the report brought forward by Justice Campbell in December of 2006. That’s why I moved it. I’d ask for a recorded vote.

**The Chair:** No further debate? I’ll ask again, any further debate? I will call the question.

## Ayes

Martel.

## Nays

Fonseca, Kular, Matthews, Ramal.

**The Chair:** It is lost.

Shall schedule K, section 9, carry? Carried.

Shall schedule K, sections 10 to 13, carry? Carried.

Moving us now to schedule K, section 14, NDP motion number 35.

**Ms. Martel:** I move that section 14 of schedule K to the bill be amended by adding the following subsection:

“Worker safety

“(7) Any subcommittee or section of the corporation involved in worker safety shall have, as integral members, experts in occupational medicine and occupational hygiene, and representatives of the Ministry of Labour, and shall consult on an ongoing basis with workplace parties.”

Again, this was a recommendation that was made by ONA, the Ontario Nurses’ Association, in its submission to this committee.

**The Chair:** Any additional debate?

Those in favour of the motion? Those opposed? The motion is lost.

Shall schedule K, section 14, carry? Carried.

Shall schedule K, sections 15 to 17, carry? Carried.

Moving us now to schedule K, section 18, and it’s government motion number 36.

**Mr. Fonseca:** I move that subsections 18(4) and (5) of schedule K to the bill be struck out and the following substituted:

“Attendance of CMOH

“(4) The chief medical officer of health, or his or her designate, is entitled to attend and to participate in any meeting of the board of directors.”

**The Chair:** Do you wish to speak to it?

**Mr. Fonseca:** No.

**Mr. Khalil Ramal (London–Fanshawe):** It’s clear.

**Ms. Martel:** Very briefly, I just think the chief medical officer of health should have a seat at the board, not just be entitled to attend and participate in meetings.

**Mr. O’Toole:** The other point may be, would they have a voting voice on the board? They have the right to attend, which is understandable, but do they have a voting voice on the board?

**The Chair:** I’m assuming the question is through me to the pseudo-parliamentary assistant?

**Mr. Fonseca:** They can actively participate in the board meetings.

**Mr. O’Toole:** And vote on resolutions or—

**Mr. Fonseca:** They cannot vote.

**Mr. O’Toole:** It’s a status position, then.

**Mr. Fonseca:** They can actively participate but not vote.

**Mr. O’Toole:** So they’re actually just there for advice.

**The Chair:** Any further debate? I’ll call the question: Those in favour of the motion? Opposed? It is carried.

Shall schedule K, section 18, as amended, carry? Carried.

Shall schedule K, sections 19 to 23, carry? Carried.

Moving us to schedule K, section 24, government motion number 37.

**Mr. Fonseca:** I move that section 24 of schedule K to the bill be struck out and the following substituted:

“CMOH directives

“24.(1) The chief medical officer of health may issue directives in writing to the corporation for the corporation to provide scientific and technical advice and oper-



ational support to any person or entity in an emergency or outbreak situation that has health implications.

“Implementation

“(2) The board of directors shall ensure that a directive of the chief medical officer of health under subsection (1) is carried out in accordance with the terms of this act, and the regulations.”

**The Chair:** Any debate? I’ll call the question: Those in favour? Opposed? Carried.

Shall schedule K, section 24, as amended, carry? Carried.

Shall schedule K, sections 25 to 34, carry? Carried.

Shall schedule K, as amended, carry? Carried.

This moves us to schedule L, government motion number 38.

**Mr. Fonseca:** I move that clause (f) of the definition of “drug” in subsection 1(1) of the Drug and Pharmacies Regulation Act, as set out in subsection 1(2) of schedule L to the bill, be struck out and the following substituted:

“(f) any ‘natural health product’ as defined from time to time by the natural health products regulations under the Food and Drugs Act (Canada), unless the product is a substance that is identified in the regulations as being a drug for the purposes of this act despite this clause, either specifically or by its membership in a class or its listing or identification in a publication,”

**The Chair:** Any debate?

Those in favour? Opposed? Carried.

Shall schedule L, section 1, as amended, carry? Carried.

Shall schedule L, sections 2 to 11, carry? Carried.

Schedule L, section 12, government motion number 39.

**Mr. Fonseca:** I move that the following section be added after section 148.2 of the Drug and Pharmacies Regulation Act, as set out in section 12 of schedule L to the bill:

“Commission powers

“148.2.1 For the purpose of determining whether a person mentioned in subsection 140(1) has committed an act of proprietary misconduct or is in breach of this act or the regulations, an inspector has all the powers of the commission under part II of the Public Inquiries Act.”

**The Chair:** Any discussion? Those in favour? Opposed? Carried.

Shall schedule L, section 12, as amended, carry? Carried.

Shall schedule L, sections 13 to 24, carry? Carried.

That moves us to schedule L, section 25, government amendment number 40.

**Mr. Fonseca:** I move that clause 161(1)(b) of the Drug and Pharmacies Regulation Act, as set out in subsection 25(1) of schedule L to the bill, be amended by adding “or identifying” after “naming”.

**The Chair:** Any debate? I’ll call the question: In favour? Opposed? Carried.

Shall schedule L, section 25, as amended, carry? Carried.

Shall schedule L, sections 26 to 33, carry? Carried.

Shall schedule L, as amended, carry? Carried.

Moving to schedule M, shall schedule M, sections 1 to 6, carry? Carried.

That brings us to schedule M, section 7, government motion number 41.

Perhaps we will do it, and then we will call a recess.

**Mr. Fonseca:** I move that clause 36(1)(h) of the Regulated Health Professions Act, 1991, as set out in subsection 7(1) of schedule M to the bill, be struck out and the following substituted:

“(h) where disclosure of the information is required by an act of the Legislature or an act of Parliament;

“(h.1) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons; or”

**The Chair:** Debate? Those in favour? Opposed? It is carried.

Shall schedule M, section 7, as amended, carry? Carried.

Shall schedule M, sections 8 to 17, carry? Carried.

I am going to call a recess for the duration of the vote. The committee stands recessed.

*The committee recessed from 1652 to 1703.*

**The Chair:** The committee is back in session. We are at schedule M, section 18, Progressive Conservative motion number 42.

**Mrs. Witmer:** I move that paragraph 9 of subsection 3(1) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 18(2) of schedule M to the bill, be struck out.

This relates to the objects, and I guess this is the deletion of—HPRAC had examined this whole issue of interprofessional collaboration, and they did not recommend that its promotion be added to the objects of the colleges, and yet we see that that has been added here. Obviously that has nothing to do with self-regulation of health professionals. I think we have to avoid politicizing Ontario’s health regulatory bodies and placing them in conflicting roles. I think the promotion of interprofessional collaboration doesn’t belong here and more appropriately would remain within the domain of the ministry. That’s why this is as here.

**The Chair:** Any other debate? Seeing none, I will call the vote: Those in favour of the motion? Those opposed? The motion is lost.

Shall schedule M, section 18, carry? Carried. Good. Thank you.

Shall schedule M, section 19, carry? Carried. Okay.

On schedule M, section 20, in the package is a notice from the government. Would you like to speak to the notice?

**Mr. Fonseca:** I can. This proposed wording of section 20, once proclaimed, would affect the status of anyone sitting on a college council today who has sat for more than nine years. Colleges have pointed out that this may compromise the ability for a council to conduct its business and to deal with ongoing complaints and discipline proceedings that the council member may be

participating in. Voting no will respond to college concerns. This amendment will negatively impact on their ability to protect the public, because their councils will not be legally constituted.

**Ms. Martel:** I have a question on this section. The net effect is to have the word “consecutive” removed if we vote this down; that’s my understanding.

The College of Physicians and Surgeons had called us to say that they wanted to see the word “consecutive” removed. The net effect, though, if we vote this down, is that “consecutive” remains in the legislation, and they’re concerned that’s going to cause them a problem in terms of being able to deal with the panels.

So can I get some clarification about why, in Bill 171, you were going to strike out “consecutive” and why you’re not doing that now?

**The Chair:** Please state your name for Hansard.

**Mr. Ryan Collier:** Ryan Collier, legal services branch, Ministry of Health and Long-Term Care.

In response to the question, if it’s striking down the amendment, it returns it to the status quo so that members of the college panel may continue to proceed in addition to an appointment that exceeded nine years of time. So members would be able to continue to sit and there would not be a necessity for the colleges to replace those members after nine years.

**Ms. Martel:** I’m sorry; where does the term “consecutive” come in, in there? They can sit for three sessions consecutively? I don’t have the original bill—not Bill 171, but the one before that deals with schedule M, the Regulated Health Professions Act—in front of me.

**Mr. Collier:** The bill proposes to strike out the word “consecutive.”

**Ms. Martel:** Yes.

**Mr. Collier:** So a member would only be able to sit for nine years in total. By not proceeding with this motion, a member may sit for nine consecutive years—may sit for nine years in total that are not necessarily consecutive.

**The Chair:** Do you need a copy of the original—

**Ms. Martel:** No. I’m assuming that CPSO made the ministry aware of its concerns of not wanting this section voted down. So can I get a sense of why that was the case and why the government has made a change from the wording that was in Bill 171? Is that a fair question?

**Mr. Collier:** The legal reason behind removing “consecutive” was to allow members to sit on a college council for a total of nine years. They may serve part of a term, come back, and receive more of a term. By changing the words to “consecutive,” as proposed in Bill 171, that means any person who had been sitting for nine days—

**Ms. Martel:** Nine years.

**Mr. Collier:** —as of the coming into force of this section, would not be able to sit on the council, at which time the council would not be properly constituted. These concerns were addressed, and this is why the government is not proceeding from a legal perspective with respect to the amendment adding the word “consecutive.”

**Mr. Fonseca:** Chair, the other colleges also asked for this, not just the CPSO.

**Ms. Martel:** Okay. If I can just put on the record, we got a call from CPSO before I came into this committee, saying that they were opposed to this motion 43, which is voting against schedule M. I don’t know what to say, except that that’s why I’m in here asking the question, because that happened just before we came in. I don’t pretend to understand all the legal things that are going on here, especially since I don’t have the other bill in front of me.

I’m just wondering, Chair—I’m not trying to cause a problem here. Is it possible at all to stand down this section just for now, and could somebody from the ministry—would it be a problem to call CPSO and ask them why they are calling us at this time?

**The Chair:** There’s a request to stand this section down. Is there unanimous consent to stand it down? Agreed. Okay, we will stand it down and we will proceed.

Shall schedule M, sections 21 to 23, carry? It’s okay to actually say it out loud.

*Interjections.*

**The Chair:** Thank you. Carried. Okay.

Schedule M, section 24: We have PC motion number 44.

1710

**Mrs. Witmer:** I move that subsection 14(1) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 24(1) of schedule M to the bill, be amended by adding “or expires” before “or who resigns as a member”.

**The Chair:** Is this a replacement motion to the one you filed earlier?

**Mrs. Witmer:** Yes, it is.

**The Chair:** So this is a new one, a new 44. So we’ll call it 44r, if you don’t mind.

**Mrs. Witmer:** That would be fine.

**The Chair:** Any debate? There being none, I will call the vote. Those in favour of motion 44r? Opposed? It is carried.

Now, Ms. Martel: Motion motion 45.

**Ms. Martel:** I move that subsection 14(1) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 24(1) of schedule M to the bill, be amended by adding “or whose certificate of registration has expired or has been terminated” after “resigns as a member”.

This amendment was part of the package that was given to the committee by the CPSO. I’m just looking very quickly for the rationale behind it. Sorry, Chair.

*Interjection.*

**Ms. Martel:** Okay. Ms. Witmer tells me it’s essentially the same. I’ll withdraw mine.

**The Chair:** Do you wish to withdraw?

**Ms. Martel:** I will withdraw. I’m sorry.

**The Chair:** Okay. Shall schedule M, section 24, as amended, carry? Carried.

Shall schedule M, sections 25 to 28, carry? Carried.



That brings us now to schedule M, section 29. The first one is government motion number 46.

**Mr. Fonseca:** I move that section 23 of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 29 of schedule M to the bill, be amended:

“1. By striking out paragraphs 1, 5, 7 and 11 of subsection (2) and substituting the following:

“1. Each member’s name, business address and business telephone number, and, if applicable, the name of every health profession corporation of which the member is a shareholder.

“1.1 The name, business address and business telephone number of every health profession corporation.

“5. A notation of every matter that has been referred by the inquiries, complaints and reports committee to the discipline committee under section 26 and has not been finally resolved, until the matter has been resolved.

“7. A notation of every finding of professional negligence or malpractice, which may or may not relate to the member’s suitability to practise, made against the member, unless the finding is reversed on appeal.

“11. Where findings of the discipline committee are appealed, a notation that they are under appeal, until the appeal is finally disposed of.”

“2. By adding the following subsection:

“Publication ban

“(2.1) No action shall be taken under this section which violates a publication ban, and nothing in this section requires or authorizes the violation of a publication ban.”

**The Chair:** Any debate? Those in favour of the motion? Opposed? It is carried.

The next motion, in theory, would be 47r. I’m going to ask that we set it aside. The numbering should probably have been applied differently than it was, and I wonder if we could do NDP motion number 48 next. We will do 47r following amendment 50.

**Ms. Martel:** I move that section 23 of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 29 of schedule M to the bill, be amended by striking out “subsections (5) and (6)” in subsection (4) and substituting “subsections (5), (6) and (6.1)” and by adding the following subsection:

“Personal health information

“(6.1) The registrar shall refuse to disclose to a member of the public or to post on the college’s website any personal health information regarding a member.”

**The Chair:** Debate?

**Ms. Martel:** Yes, there is. Can I speak to that?

**The Chair:** Yes.

**Ms. Martel:** This comes from the presentation, the written submission, that was given to us by ONA. The Ontario Nurses’ Association expressed some serious concerns with respect to this section. They said, in their submission to us, that they understand that the government is trying to achieve, with its changes, greater transparency. However, their concern around personal health information is that it’s highly sensitive and private and should

not be placed on the public register or posted for all to see on the website.

They are particularly concerned about grounds for finding in an incapacity proceeding making its way onto the website. This is not, from their perspective, a situation where the public would be put at risk because in many cases what it is talking about is specific medical treatment that is being sought by the member with respect to an alcohol or a drug addiction, and they’re undergoing that as part of terms and conditions that have been set out by the college. Those are quite different from the terms and conditions and limitations that are imposed in a discipline case.

ONA has provided us with two precedents where, if this particular amendment had been in place, personal information about the nurses involved, in terms of them getting treatment for drug and alcohol abuse and addictions, may well have ended up posted on the website. Their concern was not to undermine what the government is trying to do around transparency, and neither is it mine. I just want to be clear that what gets on the college website does not involve personal health information, i.e., a member of any profession getting treatment with respect to an addiction, be it drug, alcohol etc.

**Mr. Fonseca:** This would provide the transparency that we’re looking for, that the public’s looking for, but it also provides a mechanism to remove obsolete information about health care providers and protections against the unnecessary release of personal health information about health providers.

**Ms. Martel:** It’s not so much that I’m concerned about what gets removed as what gets put on in the first place. I remain unconvinced, regrettably, that what the government has in this current section is going to prevent that kind of information from coming up on the website.

**The Chair:** I call the vote: Those in favour? Opposed? The motion is lost.

That brings us to NDP motion number 49.

**Ms. Martel:** I move that clause 23(6)(a) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 29 of schedule M to the bill, be amended by adding “if the information regarding the member was a discipline finding in respect of which the penalty ordered was only a fine or reprimand” at the end.

**The Chair:** Do you wish to speak to it?

**Ms. Martel:** Sorry, if I could find my section quickly, I would like to. Hang on.

**The Chair:** Ms. Witmer.

**Mrs. Witmer:** We have a similar motion, and it comes from CPSO. This proposes to provide the discipline committee with a new ability to order that the registrar, the way it’s worded, not disclose certain information to the public or post it on the college website if more than six years have passed since the information was prepared or last updated.

They’re suggesting that the public would be better protected if the information regarding the member that would not be disclosed after six years had passed was limited to a discipline finding in respect to which the

penalty ordered was only a fine or a reprimand, and if all serious penalties remained on the register indefinitely, as they currently do now under the combined effects of the legislation and various college bylaws.

1720

**The Chair:** Did you move that as an amendment to—

**Mrs. Witmer:** No, I was giving the rationale, because we had a similar amendment. We had the same amendment.

**Ms. Martel:** She was helping me out.

**The Chair:** Okay. Ms. Martel?

**Ms. Martel:** I'll just add to that. To be clear, after six years, there's a very clear idea of what can be removed and what can't. Only those things that involve a reprimand or a fine are things that can be removed, even after six years. The rest would have to stay because it would be of a much more serious nature that the public should be made aware of.

**The Chair:** If there's no other discussion, I will call for the vote on amendment number 49.

Those in favour? Opposed? It is lost.

That brings us to amendment number 50. Do you wish to move it so that I can rule it out of order?

**Mrs. Witmer:** Sure. I move that clause 23(6)(a) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 29 of schedule M to the bill, be amended by adding "if the information regarding the member was a discipline finding in respect of which the penalty ordered was only a fine or reprimand" at the end.

This was brought forward by CPSO.

**The Chair:** It is out of order, only because it's exactly identical to the previous motion.

That brings us now to government motion number 47r. That has been distributed.

*Interjection.*

**Mrs. Witmer:** I haven't been on the list, either.

**Mr. O'Toole:** It's an exclusive list that only the Liberals get.

**The Chair:** Well, perhaps you could proceed on faith, John.

*Interjections.*

**Mr. Fonseca:** Chair?

**The Chair:** The floor is yours.

**Mr. Fonseca:** I move that subsections 23(4) to (9) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 29 of schedule M to the bill, be struck out and the following substituted:

"Access to information by the public

"(4) All of the information required by paragraphs 1 to 12 of subsection (2) and all information designated as public in the bylaws shall, subject to subsections (5), (5.1), (5.2), (5.3) and (6), be made available to an individual during normal business hours, and shall be posted on the college's website in a manner that is accessible to the public or in any other manner and form specified by the minister.

"When information may be withheld from the public

"(5) The registrar may refuse to disclose to an individual or to post on the college's website an address or

telephone number or other information designated as information to be withheld from the public in the bylaws if the registrar has reasonable grounds to believe that disclosure may jeopardize the safety of an individual.

"Same

"(5.1) The registrar may refuse to disclose to an individual or to post on the college's website information that is available to the public under subsection (4), if the registrar has reasonable grounds to believe that the information is obsolete and no longer relevant to the member's suitability to practise.

"Same, personal health information

"(5.2) The registrar shall not disclose to an individual or post on the college's website information that is available to the public under subsection (4) that is personal health information, unless the personal health information is that of a member and it is in the public interest that the information be disclosed.

"Restriction, personal health information

"(5.3) The registrar shall not disclose to an individual or post on the college's website under subsection (5.2) more personal health information than is reasonably necessary.

"Personal health information

"(5.4) In subsections (5.2) and (5.3),

"personal health information' means information that identifies an individual and that is referred to in clauses (a) through (g) of the definition of 'personal health information' in subsection 4(1) of the Personal Health Information Protection Act, 2004.

"Other cases when information may be withheld

"(6) The registrar shall refuse to disclose to an individual or to post on the college's website information required by paragraph 6 of subsection (2) if,

"(a) a finding of professional misconduct was made against the member and the order made was only a reprimand or only a fine, or a finding of incapacity was made against the member;

"(b) more than six years have passed since the information was prepared or last updated;

"(c) the member has made an application to the relevant committee for the removal of the information from public access because the information is no longer relevant to the members' suitability to practise, and if,

"(i) the relevant committee believes that a refusal to disclose the information"—

**The Chair:** I don't wish to interrupt, but I'm conscious of the time. I'm wondering if we could continue after.

*Interjections.*

**The Chair:** Keep going? Okay.

**Mr. Fonseca:**—"outweighs the desirability of public access to the information in the interest of any person affected or the public interest, and

"(ii) the relevant committee has directed the registrar to remove the information from public access; and

"(d) the information does not relate to disciplinary proceedings concerning sexual abuse as defined in clause



(a) or (b) of the definition of 'sexual abuse' in subsection 1(3).

"Information from register

"(7) The registrar shall provide to an individual a copy of any information in the register that the individual is entitled to obtain, upon the payment of a reasonable fee, if required.

"Positive obligations

"(8) Subject to subsection (6), where an individual inquires about a member, the registrar shall make reasonable efforts to ensure that the individual is provided with a list of the information that is available to the public under subsection (4).

"Meaning of results of proceeding

"(9) For the purpose of this section and section 56, "result", when used in reference to a disciplinary or incapacity proceeding, means the panel's finding, particulars of the grounds for the finding and the order made, including any reprimand."

**The Chair:** The committee's in recess.

*The committee recessed from 1727 to 1736.*

**The Chair:** The committee is back in session.

We have just had government motion 47r moved. Any additional debate or discussion?

Seeing none, I will call the question: Those in favour? Those opposed? It is carried.

Shall schedule M, section 29, as amended, carry? It is carried.

We stood down government motion number 43 and we will now return to it.

Schedule M, section 20. This is not an amendment. This is a notice.

Shall schedule M, section 20, carry?

**Interjection:** Carried.

**The Chair:** You may want to rethink that because I'm going to re-call it.

Shall schedule M, section 20, carry?

**Interjection:** No.

**The Chair:** No.

Shall schedule M, section 30, carry? Carried.

That moves us now to schedule M, section 31. We're dealing first with Progressive Conservative motion number 51.

**Mrs. Witmer:** I move that subsection 25(6) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be amended by adding "unless a longer period is required to preserve the integrity of the investigation" at the end of the portion before clause (a).

This is from CPSO. In their written submission it does point out that the RHPA currently "does not specify a set time period for the provision of notice to a member who is subject to a complaint." They're saying the appointment of investigators and the obtaining and execution of a search warrant will generally take more than 14 days, and therefore there needs to be a mechanism to allow for an exception to the 14-day general notice provision for these types of cases. The CPSO is therefore "supportive of a general provision imposing a time limit, but wishes

to stress the importance of allowing for exceptions in certain cases where at least some investigation needs to be done prior to notifying the subject member."

As an example, "a sexual abuse, fraud or serious prescribing complaint may require the college to obtain an appointment of investigators by the ICR committee and in some cases, perhaps even a search warrant, to obtain original medical records prior to notifying the member of the complaint out of concern for the preservation of the integrity of evidence. That is why in these types of cases, if the member under investigation is aware that a complaint against him/her has been submitted to the college before the investigation commences, the integrity of evidence may be jeopardized." That is from the College of Physicians and Surgeons of Ontario's submission.

**The Chair:** Any further debate?

**Mr. Fonseca:** Chair, we can't support this. The reason is, in the words of Minister Smitherman, "Justice delayed is justice denied."

**The Chair:** If there's no other discussion, I will call the vote.

Those in favour of the amendment? Opposed? The motion is lost.

Okay. This is an identical one. If you wish, you can move it and I'll rule it out of order or you could withdraw it.

**Ms. Martel:** I'll withdraw.

**The Chair:** Withdrawn.

That brings us to government motion number 53.

**Mr. Fonseca:** I move that subsection 25.1(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be amended by striking out "concerning the same matter" at the end.

**The Chair:** Discussion?

Seeing none, those in favour? Opposed? It's carried.

PC motion number 54.

**Mrs. Witmer:** I move that subsection 25.1(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be struck out.

Again, this is coming from the CPSO. The college points out that "As regulator and in order to protect the public, it cannot ignore information that it has been given regardless of where it comes from. For example, during the course of ADR, a member could inform the college that his/her misconduct has extended to several other patients. The current version of the bill would prohibit the college from acting upon this very serious information in the public interest."

Therefore, the college suggests, "Requiring all information obtained during the course of the ADR process to remain confidential places the regulator in an untenable position should he become aware of serious information during the ADR process and be precluded from further investigating or acting upon it." This comes from the College of Physicians and Surgeons.

**The Chair:** Debate?

I'll call the vote: Those in favour of the motion? Opposed? It is lost.

That brings us to PC motion number 55.

**Mrs. Witmer:** I move that subsection 25.2(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be amended by inserting "the Chair of"

(a) at the beginning; and

(b) before "Committee is of the opinion".

Again, this comes to us from CPSO: "The ICR committee may specify a period of time of less than 30 days in which the member who is the subject of a complaint or a report may make written submissions, and inform the member to that effect, if the committee is of the opinion, on reasonable and probable grounds, that the conduct of the member exposes or is likely to expose his or her patients to harm or injury."

"It would" therefore "be important to enable an entity other than the ICR committee, which operates through panels, to reduce the time period for reply in these exceptional cases. If a panel of the ICR committee needs to be struck, the 30-day time period that is sought to be abridged would be subsumed in the time period it takes to strike a panel. A workable alternative would be to specifically provide that this function may be performed by the chair or other single member of the ICR committee."

**The Chair:** Debate?

Seeing none, I'll call the question: Those in favour? Opposed? The motion is lost.

NDP motion number 56.

**Ms. Martel:** I move that subsection 25.2(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be struck out and the following substituted:

"Exception

"(2) The chair of the inquiries, complaints and reports committee may specify a period of time of less than 30 days in which the member may make written submissions, and inform the member to that effect, if the chair is of the opinion, on reasonable and probable grounds, that the conduct of the member exposes or is likely to expose his or her patients to harm or injury."

This is an amendment that was put forward by CPSO. The rationale is the following: "The ICR committee may specify a period of time of less than 30 days in which the member who is the subject of a complaint or report may make a written submission and inform the member to that effect, if the committee" has grounds to believe that the conduct will expose his or her patients to harm or injury."

"It would be important to enable an entity other than the ICR committee, which operates through panels, to reduce the time period for reply in these exceptional cases. If a panel of the ICR committee needs to be struck, the 30-day time period that is sought to be abridged would be subsumed in the time period it takes to strike a panel. A workable alternative would be to specifically provide that this function may be performed by the chair or other single member of the ICR committee."

**The Chair:** Discussion? Those in favour of the motion? Opposed? The motion is lost.

Government motion number 57.

**Mr. Fonseca:** I move that paragraph 1 of subsection 26(1) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be amended by adding "if the allegation is related to the complaint or the report" at the end.

**The Chair:** Any debate? Those in favour? Opposed? Motion is carried.

NDP motion number 58, Ms. Martel.

**Ms. Martel:** Thank you, Chair. I move that subsection 26(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be struck out and the following substituted:

"Prior decisions

"(2) A panel of the inquiries, complaints and reports committee, shall, when investigating a complaint or considering a report currently before it, consider all of its available prior decisions involving the member, which are strikingly similar, including decisions made when that committee was known as the complaints committee, and all available prior decisions involving the member, which are strikingly similar of the discipline committee, the fitness to practise committee and the executive committee, unless the decision was to take no further actions under subsection (5)."

This amendment was proposed to us by the Ontario Nurses' Association. They had extensive comments to make about it in their submission before us under subsection (4). That's why I put it forward to this committee.

**The Chair:** Debate? In favour? Opposed? Lost.

Government motion number 59.

**Mr. Fonseca:** I move that subsection 26(3) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill, be struck out and the following substituted:

"Quality assurance

"(3) In exercising its powers under paragraph 4 of subsection (1), the panel may not refer the matter to the quality assurance committee, but may require a member to complete a specified continuing education or remediation program."

**The Chair:** Any discussion? In favour? Opposed? Carried.

PC motion number 60.

**Mrs. Witmer:** I move that subsection 28(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 31 of schedule M to the bill be struck out and the following substituted:

"ADR

"(2) Where there has been a referral to an alternative dispute resolution process under section 25.1, the time requirements under this section are suspended until the alternative dispute resolution process is completed."

Again, this is from CPSO: "The ADR process with respect to a complaint should not run concurrently with an investigation as it would be extremely resource-intensive for the college, the member, and the complainant



to have two very similar concurrent processes. The college, the complainant and the member would all be duplicating efforts and doubling the use of resources if required to undergo two processes about the exact same matter concurrently."

Therefore, this amendment would mean that the investigation should not commence until the ADR process is complete. Then we'll only need to proceed if the ADR process has failed.

**The Chair:** Further debate? Those in favour?

**Mr. O'Toole:** I want to clarify: Is there anything in this legislation that supports an alternative dispute resolution process, or is it all going to go to this other process, right before the board? That's what's been recommended, having another mediated process.

**Mr. Collier:** Ryan Collier, legal services branch, Ministry of Health and Long-Term Care. Schedule M to Bill 171 introduces and puts into the statute a process for alternative dispute resolution, and it allows the colleges, a member and a complainant to address the concerns they may have through an alternative dispute resolution process. However, it is inherent that the alternative dispute resolution process remain confidential. The motion to which you are speaking to ensures that the confidentiality of the process remains, and that the college maintain its statutory duty to investigate a complaint through the ICR committee if it's necessary, or if a resolution is no longer achieved through the ADR process.

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**Mr. O'Toole:** Okay, but there is an ADR in there.

**Mr. Collier:** Yes.

**The Chair:** I'll call the question: Those in favour of the motion? Those opposed? The motion is lost.

Shall schedule M, section 31, as amended, carry? Carried.

Shall schedule M, section 32, carry? Carried.

Schedule M, section 33: We have government notice 61. Would you like to speak to it?

**Mr. Fonseca:** Just that the government recommends voting against section 33.

**The Chair:** I'm going to ask the question: Shall schedule M, section 33, carry? No.

Shall schedule M, sections 34 to 36, carry? Carried.

*Interjections.*

**The Chair:** This brings us to schedule M, section 37. I would remind the government members that you're not to have fun here. This brings us to NDP amendment 62.

**Ms. Martel:** I move that subsection 37(2) and (3) of schedule M to the bill be struck out.

*Interjection.*

**Ms. Martel:** There was another one that had (3).

*Interjection.*

**The Chair:** So 62 is withdrawn? Okay, 62 is not being moved, 63 is not being moved, and 64 is being moved by Ms. Martel.

**Ms. Martel:** Motion 64 appears as a government motion. We agreed with the government that if I put in

subsection (3), they would be amenable to it. So that's the change that was made.

**The Chair:** Okay. But you are moving motion number 64?

**Ms. Martel:** Sure. If you want me to move 64, I'll move 64.

**The Chair:** It's now done. You've just moved government motion number 64.

*Interjections.*

**The Chair:** You make your own fun at these things, folks, and this will confuse people 100 years from now.

Do you wish to speak in support of the government motion?

*Interjection.*

**The Chair:** I understand that. That's my feeble attempt at humour. It's late in the day, and I resent being here.

Ms. Martel, do you wish to speak to your motion?

**Ms. Martel:** Yes—

**The Chair:** Since you moved it, you have to support it.

**Ms. Martel:** I know. It was from CPSO, that I know.

**The Chair:** Given that it may pass, it may even be possible to simply go to the vote.

**Ms. Martel:** Yes, let's just do that, Chair.

**The Chair:** Okay. I'll call the vote. Those in favour? Those opposed? Carried.

PC motion number 65.

**Mrs. Witmer:** I move that section 37 of schedule M to the bill be amended by adding the following subsection:

"(2.1) Subsection 38(2) of schedule 2 to the act is repealed and the following substituted:

"(2) A panel shall be composed of at least three and no more than five persons,

"(a) at least two of whom shall be persons appointed to the council by the Lieutenant Governor in Council; or

"(b) at least one of whom shall be a person appointed to the council by the Lieutenant Governor in Council and one of whom shall be a person,

"(i) who was appointed to the discipline committee by the Lieutenant Governor in Council; and

"(ii) who is a judge of the federal court, Supreme Court of Canada or of a superior, district or county court of a province or a person who is qualified for appointment to, or has retired from, such a judicial office."

This is from CPSO. I guess the one thing we need to recognize is that "the college's current discipline process has become increasingly litigious and procedurally demanding as it faces growing pressure from defence lawyers," who have been hired and, obviously, "the courts. Contested hearings are prolonged as discipline panels confront issues and arguments that are progressively complex and strongly challenged.

"Independent legal advice as currently structured is not designed to direct the panel, such that the panel is left to make procedural technical decisions without the requisite expertise." I think that's important. "For example, when objections occur during the course of a case, the panel must receive advice from ILC, followed by

submissions of counsel for both parties on the advice of ILC, and then make a decision in an area of expertise outside their own. Each ILC has a different approach to how directive they will be, with the result that there can be inconsistencies, thereby causing further confusion for the panel members. The panel then must be able to write written reasons that will withstand judicial scrutiny."

Therefore, the college has recommended, and I know it's supported by other colleges, "that a small pool of three to four retired judges and/or experienced litigators be appointed by the Lieutenant Governor in Council to the college's discipline committee." This approach, by the way, has been successful in other jurisdictions, including Nova Scotia, Quebec and Saskatchewan.

Furthermore, a legal chair "would add value by making procedural decisions in consultation with the panel and by assisting with writing decisions," bringing "additional expertise to the discipline panel that would:

"—enhance collaborative decision-making and build greater capacity within a panel;

"—allow the medical panel members, at the same time, to focus on the medical care and professional conduct issues; and

"—enable the panel to be more proficient at deciding procedural issues and arguments during hearings, and at preparing its reasons."

The key here is that hearings, folks, have changed. They are now contested and they are prolonged and they are facing issues and arguments that are increasingly complex and strongly challenged. There is a need for someone who has this type of expertise.

**The Chair:** Any additional discussion? I'll call the vote. Those in favour of the amendment? Those opposed? The motion is lost.

That brings us to NDP motion number 66.

**Mrs. Witmer:** Mr. Chair, I think that the sections we're debating and that are being defeated really do demonstrate the lack of consultation on the part of the government. This bill has not been opened for 15 years. They seem to be unable to recognize the changes that have taken place during that time as far as the disciplinary hearings are concerned. I think this unwillingness to support this proposal that I just had put forward really is more a result of a lack of will on the part of the government to do the policy work that would be necessary

and, at the end day, I think, would certainly enhance the process for all concerned.

I'm really concerned that, after 15 years, there is so little change being made in order to move this process forward on behalf of all the parties concerned.

**The Chair:** Thank you. NDP motion number 66?

**Ms. Martel:** My motion was the same as Mrs. Witmer's 65, which has been voted down, so I will withdraw it.

**The Chair:** Thank you. Now I shall ask the question: Shall schedule M, section 37, as amended, carry? Carried.

Shall schedule M, sections 38 to 51, carry? Carried.

We're now at schedule M, section 52, government motion number 67.

**Mr. Fonseca:** Schedule M to the bill, subsection 52(3) (subsections 69(3) and (5) of schedule 2 to the Regulated Health Professions Act, 1991)

I move that:

"1. subsection 69(3) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 52(3) of schedule M to the bill, be amended by adding 'or the college' after 'A member',

"2. subsection 69(5) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 52(3) of schedule M to the bill, be struck out and the following substituted:

"“Limitations on applications

"“(5) The panel, in disposing of an application by a member under subsection (3), may fix a period of time not longer than six months during which the member may not make a further application.”"

**The Chair:** Debate? Hearing none, those in favour of the motion? Those opposed? The motion is carried.

Shall schedule M, section 52, as amended, carry? Carried.

Schedule M, sections 53 and 54: Shall they carry? Carried.

I think that's it. Committee, it now being 6 o'clock, we'll adjourn. We will reconvene next Monday, the 14th, following routine proceedings and hopefully complete this. We stand adjourned.

*The committee adjourned at 1803.*





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#### **Also taking part / Autres participants et participantes**

Mr. Ryan Collier, legal counsel,  
Ministry of Health and Long-Term Care

#### **Clerk / Greffier**

Mr. Trevor Day

#### **Staff / Personnel**

Mr. Ralph Armstrong, legislative counsel





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Second Session, 38<sup>th</sup> Parliament

## Assemblée législative de l'Ontario

Deuxième session, 38<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 14 May 2007

# Journal des débats (Hansard)

Lundi 14 mai 2007

## Standing committee on social policy

Health System  
Improvements Act, 2007

## Comité permanent de la politique sociale

Loi de 2007 sur l'amélioration  
du système de santé

Chair: Ernie Parsons  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Monday 14 May 2007

Lundi 14 mai 2007

*The committee met at 0906 in committee room 1.*HEALTH SYSTEM  
IMPROVEMENTS ACT, 2007LOI DE 2007 SUR L'AMÉLIORATION  
DU SYSTÈME DE SANTÉ

Consideration of Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts / Projet de loi 171, Loi visant à améliorer les systèmes de santé en modifiant ou en abrogeant divers textes de loi et en édictant certaines lois.

**The Chair (Mr. Ernie Parsons):** Good morning, everyone. We'll call to order the standing committee on social policy dealing with Bill 171, doing clause-by-clause.

I believe we are at amendment number 68, which is a PC motion.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** I move that clause 75(1)(b) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 55 of schedule M to the bill, be struck out and the following substituted:

"(b) the inquiries, complaints and reports committee has received a report from the quality assurance committee, and approves of the appointment;"

**The Chair:** Discussion?

**Mrs. Witmer:** This is as a result of a request from CPSO, which believes that section 75 should reflect that it is the ICR committee, not the registrar, that gets the report. This would mirror the current provisions of who receives the report, but changes the executive committee to the ICR.

**The Chair:** Any other discussion?

**Mr. Peter Fonseca (Mississauga East):** Mr. Chair, we won't be supporting this. The reason is that we've been told by legal that it is incompletely drafted.

*Interruption.*

**The Chair:** Could we move the BlackBerries away from the mic.

**Mr. Fonseca:** If you want more clarification, we can bring up the ministry legal staff.

**Mrs. Witmer:** Right. They can talk to CPSO since you're going to reject it.

**The Chair:** Hearing no other discussion, I will call the motion.

Those in favour of the amendment? Those opposed? The amendment is lost.

Next is government motion number 69.

**Mr. Fonseca:** I move that clause 75(1)(b) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 55 of schedule M to the bill, be struck out and the following substituted:

"(b) the inquiries, complaints and reports committee has received information about a member from the quality assurance committee under paragraph 4 of subsection 80.2(1) and has requested the registrar to conduct an investigation; or"

**The Chair:** Discussion? If there's no discussion, those in favour? Opposed? It's carried.

Shall schedule M, section 55, as amended, carry? It is carried.

Shall schedule M, section 56 carry? It is carried.

That brings us to schedule M, section 57: NDP motion number 70.

**Ms. Shelley Martel (Nickel Belt):** I'm looking ahead and see that Mrs. Witmer has an amendment on this section and so does the government. I think the intention of all three is the same: to ensure that an investigator, if required, can go into a dwelling of a member if there was evidence that has to be sought. What I'll do is stand mine down. I'm not sure there is much difference between all three—the government's is arranged a little bit differently—so I'll withdraw it and let them move theirs.

**The Chair:** Okay. That brings us to PC motion number 71.

**Mrs. Witmer:** My motion is similar to the government's and Ms. Martel's. It accomplishes what is being looked for here, so I'll stand mine down.

**The Chair:** That brings us to government motion number 72.

**Mr. Fonseca:** I move that section 57 of schedule M to the bill be struck out and the following substituted:

"57. Subsections 77(1) and (2) of schedule 2 to the act are repealed and the following substituted:

"Entries and searches

"(1) A justice of the peace may, on the application of the investigator made without notice, issue a warrant authorizing an investigator to enter and search a place and examine any document or thing specified in the warrant if the justice of the peace is satisfied that the investigator has been properly appointed and that there are reasonable and probable grounds established upon oath for believing that,

“(a) the member being investigated has committed an act of professional misconduct or is incompetent; and

“(b) there is something relevant to the investigation at the place.

“Hours of execution

“(2) A warrant issued under subsection (1) may be executed only between 8 a.m. and 8 p.m. unless the warrant specifies otherwise.

“Application for dwelling

“(2.1) An application for a warrant under subsection (1) to enter a dwelling shall specifically indicate that the application relates to a dwelling.”

**The Chair:** Discussion? Hearing none, those in favour of the motion? Those opposed? It is carried.

Shall schedule M, section 57, as amended, carry? It is carried.

Shall schedule M, sections 58 and 59 carry? Carried.

That brings us to schedule M, section 60, and we have PC motion number 73.

**Mrs. Witmer:** I move that paragraph 2 of subsection 80.2(1) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 60 of schedule M to the bill, be amended by adding “or indefinite” after “specified” in the portion before subparagraph i.

Again, this comes from CPSO. They believe: “It would be helpful to expressly state ... terms, conditions or limitations imposed in this context.... The indefinite period of time may be required in cases in which the QAC wishes to impose restrictions until a member has shown that s/he has sufficiently remedied any deficiencies that it is safe for the restriction to be removed. It is unclear if this could be accomplished under the current wording of the amendment.” Therefore, by adding the word “indefinite,” it would be clearer.

**The Chair:** Any additional discussion?

**Mr. Fonseca:** Chair, we feel that the word “indefinite” and setting up that indefinite term would be inconsistent with our goal.

**The Chair:** I will call the vote.

Those in favour of the amendment? Opposed? It is lost.

Government motion number 74.

**Mr. Fonseca:** I move that paragraph 5 of subsection 80.2(1) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 60 of schedule M to the bill, be struck out.

**The Chair:** Discussion? I will call the vote.

Those in favour? Those opposed? Carried.

Shall schedule M, section 60, as amended, carry? Carried.

Schedule M, section 61: PC motion number 75.

**Mrs. Witmer:** I move that subsection 83(2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 61(2) of the bill, be amended by adding “or failed to co-operate with the quality assurance committee or assessor or participate in the quality assurance program or a specified program or assessment”.

Again, this comes from CPSO. The proposed legislation “includes a narrow provision which would allow otherwise protected information to be disclosed by the QAC or a QA assessor to another committee, where relevant to a proceeding before that committee. Specifically, the information that may be disclosed includes only an allegation of giving false information to QAC or an assessor. The other existing provisions that limit the sharing of quality assurance information could act to prohibit this flow of information are absent this provision.”

This proposal by the college states that the exception allowing the disclosure of information must also explicitly include information related to an allegation of failure to co-operate with a QAC or assessor or to participate in the quality assurance program or a specified program of assessment. Without this important change, the college’s ability to do anything about a member who fails to co-operate with the QAC or assessor may be severely compromised, as it may not be permitted to share the information underlying the failure to co-operate.

**The Chair:** Other discussion?

**Mr. Fonseca:** The government doesn’t support this motion. It’s not necessary as we already permit this disclosure in subsection 61(1) of schedule M and subsection 83(1).

**The Chair:** If there is no other discussion, I will call the vote.

Those in favour of the motion? Those opposed? The motion is lost.

Shall schedule M, section 61 carry? It is carried.

Shall schedule M, section 62 carry? Carried.

The brings us to schedule M, section 63 and NDP motion number 76.

**Ms. Martel:** I move that section 63 of schedule M to the bill be struck out and the following substituted:

“63. Section 85.2 of Schedule 2 to the act is repealed and the following substituted:

“Reporting by facilities

“85.2(1) A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility is incompetent or incapacitated and such incompetence or incapacity is likely to expose a patient to harm or injury or has sexually abused a patient.

“When non-individuals have reasonable grounds

“(2) For the purposes of subsection (1), a person who operates a facility but who is not an individual shall be deemed to have reasonable grounds if the individual who is responsible for the operation of the facility has reasonable grounds.

“If name not known

“(3) A person who operates a facility is not required to file a report if the person does not know the name of the member who would be the subject of the report.”

Can I speak to that, Chair?

**The Chair:** Yes.

**Ms. Martel:** This concern was raised to all of us by the Ontario Nurses’ Association. I am going to take a



moment to read into the record their concerns around this particular section that I think are legitimate and underline why I have moved the motion: "ONA has serious concerns with respect to the proposed legislative changes ... which will require mandatory reporting in all situations where a facility operator has reasonable grounds to believe a member who practises at the facility may be incompetent or incapacitated.

"The proposed amendments to the code will, in future, obligate a facility operator to report to the college whenever it has reasonable grounds to believe that a member who practises at that facility is incompetent or incapacitated. The report must be made immediately if the facility operator has reasonable grounds to believe that such incompetence or incapacity is likely to expose a patient to harm or injury and there is an urgent need for intervention.

"We understand that the government has introduced these proposed changes in order to" ensure "public safety. However, ONA is of the opinion that the mandatory reporting obligation does not have to be so all encompassing in order to achieve that goal and will place an unnecessary stressor on health care professionals at a time when the focus should be on treatment and health.

"ONA has worked hard over the years to encourage employers to deal with concerns regarding incompetence or incapacity in a non-culpable fashion, if the member suffers from an underlying disability. As a result, in many cases where an employer raises concerns regarding a member's incompetence or incapacity, the matter is resolved by the member acknowledging that there is an underlying disability. The member goes ... on sick leave and undergoes appropriate treatment. A member returns to work upon obtaining medical clearance, in some cases with restrictions, which are accommodated by the employer.

"Most of the cases are not reported to the college since the member is acting responsibly, co-operating with the employer and there is no public safety concern. The focus is on the member achieving good health and ensuring a safe return to work at the earliest possible time. This can be done in a direct and expeditious manner since it's a matter between the employer and the member.

"However, in the cases where an employer has chosen to report to the college even though the member is proceeding responsibly and co-operatively, there has usually been a serious delay in returning the member to work after medical clearance has been obtained. This, in turn, has caused significant emotional and financial stress for the member.

"We've had several recent cases where the member has had to wait over six months after obtaining medical clearance for the college case to be concluded so the member could return to work. The result of the college case was to impose terms, conditions and limitations on the member's certificate of registration consistent with the medical clearance, so an earlier return to work would not have endangered the public in any way. Unfortunately, the members, upon obtaining medical clearance,

were cut off disability benefits and endured significant financial hardship while waiting for the college matter to come to a close.

"We are also concerned that a mandatory report of all members will negatively impact our attempts to have members disclose their health condition and seek appropriate treatment. It's often very difficult for members when confronted with concerns about incompetence and incapacity to acknowledge their underlying health problem. Most of the underlying health conditions which precipitate concerns about incompetence and incapacity are substance dependence or other psychiatric conditions. Unfortunately, there is still a stigma in our society with respect to individuals who suffer from these conditions. This makes it difficult for members to first make that acknowledgement and seek treatment—more difficult if the health care professional must share the intimate details of his or her health with the college as well as an employer.

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"The standing committee and the government also need to understand that a report to the college causes significant fear and stress for a healthy member, but for a disabled member who is confronting and dealing with a health condition, the fear and stress is magnified and detracts from time and energy better spent on getting well.

"While we understand and support the government's mandatory reporting obligation where the public is at risk, we do not endorse a reporting obligation which extends to a member who deals with incompetence and incapacity concerns in a responsible fashion by acknowledging an underlying disability, withdrawing from practice, undergoing appropriate treatment and co-operating with the employer. A report to the college in these circumstances is unnecessary to protect the public and flies in the face of humane, prudent and expedient efforts to deal with the concerns underlying incompetence or incapacity in a non-culpable fashion, if there is an underlying disability."

Finally, "we submit that the mandatory reporting obligation regarding incompetence and incapacity concerns should be amended to apply only to situations where the public is at risk. The language of the proposed legislative changes could simply be revised, so a facility operator would only be obliged to report to the college whenever it has reasonable grounds to believe that a member who practises at that facility is incompetent or incapacitated and such incompetence or incapacity is likely to expose a patient to harm or injury."

**The Chair:** Any other discussion?

**Mr. Fonseca:** I'd like to thank Ms. Martel for her comments, but the government won't be supporting this motion. We still find that it is too limiting and too narrow.

**The Chair:** If there is no other discussion, I will call the motion. Those in favour? Opposed? The motion is lost.

Still on the same section, we are dealing with government motion number 77.

**Mr. Fonseca:** I move that subsection 63(2) of schedule M to the bill be struck out.

**The Chair:** If there is no discussion, I will call the vote. Those in favour? Opposed? It is carried.

Shall schedule M, section 63, as amended, carry? Carried.

This brings us to schedule M, section 64, NDP motion number 78.

**Ms. Martel:** This related to the earlier motion that I moved regarding reporting by facilities. Since it's been voted down, I'll withdraw it.

**The Chair:** So I will ask, shall schedule M, section 64, carry? Carried.

We now have a new section. Government motion number 79.

**Mr. Fonseca:** I move that schedule M to the bill be amended by adding the following sections:

"64.1 Schedule 2 to the act is amended by adding the following sections:

"Reporting by members re: offences

"85.6.1(1) A member shall file a report in writing if the member has been found guilty of an offence.

"Timing of report

"(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding of guilt.

"Contents of report

"(3) The report must contain,

"(a) the name of the member filing the report;

"(b) the nature of, and a description of the offence;

"(c) the date the member was found guilty of the offence;

"(d) the name and location of the court that found the member guilty of the offence; and

"(e) the status of any appeal initiated respecting the finding of guilt.

"Publication ban

"(4) The report shall not contain any information that violates a publication ban.

"Same

"(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban.

"Additional reports

"(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding of guilt as the result of an appeal.

"Reporting by members re: professional negligence and malpractice

"85.6.2(1) A member shall file a report in writing if there has been a finding of professional negligence or malpractice made against the member.

"Timing of report

"(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding made against the member.

"Contents of report

"(3) The report must contain,

"(a) the name of the member filing the report;

"(b) the nature of, and a description of the finding;

"(c) the date that the finding was made against the member;

"(d) the name and location of the court that made the finding against the member; and

"(e) the status of any appeal initiated respecting the finding made against the member.

"Publication ban

"(4) The report shall not contain any information that violates a publication ban.

"Same

"(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban.

"Additional reports

"(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding made against the member as the result of an appeal."

**The Chair:** Discussion? Hearing none, those in favour of the amendment? Opposed? It is carried.

That brings us to schedule M, section 65, PC motion number 80.

**Mrs. Witmer:** I move that subsection 85.7(10) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in section 65 of schedule M to the bill, be struck out and the following substituted:

"Same

"(10) Funding may be used to pay for therapy or counselling that was provided at any time after the sexual abuse took place."

Again, this has come to us from CPSO. They believe that the proposed legislation would allow a person who has become eligible for funding to pay for therapy or counselling to use that funding to pay for therapy received before the person became eligible but after a complaint was filed. The current drafting of the legislation, according to them, would prevent an individual from accessing needed funding in this regard. Therefore, they believe, "The legislation needs to explicitly state that funding to pay for therapy or counselling is allowed to be made retroactively to the date of the sexual abuse, irrespective of whether or when a complaint or a report is made to the college.

"For example, criminal convictions against a member may have been made, a member may have died, and the victim may not wish to complain to the college, but should still be able to access funding for therapy, even if the therapy has already commenced. If eligibility requirements specified in the regulations are met, victims should be able to access funding for therapy they receive any time after the sexual abuse occurred, even if they choose not to complain to the college as they do not wish to go through a hearing again."

**The Chair:** Any other discussion? I'll call the vote, then. Those in favour of the amendment? Opposed? It is carried.

Shall schedule M, section 65, as amended, carry? It is carried.



Shall schedule M, sections 66 to 69, carry? Carried.

That brings us to a new section.

**Mr. Fonseca:** Chair, I ask that we open up this section, and I ask for all-party consent to do that.

**The Chair:** You need to move the motion.

**Mr. Fonseca:** I move a motion to ask to open up this section—

**The Chair:** No, no. You need to move your amendment.

**Mr. Fonseca:** Move our motion first? Okay.

**The Chair:** I will then rule it out of order. We can then proceed and ask for unanimous consent.

**Mr. Fonseca:** All right. I move that schedule M to the bill be amended by adding the following section:

“69.1 Section 85.9 of schedule 2 to the act is amended by adding ‘who are members of the college’ at the end.”

**The Chair:** Unfortunately, it’s out of order. If you wish, you may ask for unanimous consent to open up.

**Mr. Fonseca:** I ask for unanimous consent, Chair.

**The Chair:** Do I hear unanimous consent? It is agreed. Proceed.

**Mr. Fonseca:** I move that schedule M to the bill be amended by adding the following section:

“69.1 Section 85.9 of schedule 2 to the act is amended by adding ‘who are members of the college’ at the end.”

**The Chair:** Discussion? I will call the vote. Those in favour of the motion? Those opposed? It is carried.

Shall schedule M, sections 70 to 72, carry? Carried.

That brings us to schedule M, section 73, government motion number 82.

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**Mr. Fonseca:** I move that clause 94(1)(1.2) of schedule 2 to the Regulated Health Professions Act, 1991, as set out in subsection 73(2) of schedule M to the bill, be struck out and the following substituted:

“(1.2) prescribing information as information to be kept in the register for the purposes of paragraph 13 of subsection 23(2), designating information kept in the register as public for the purposes of subsection 23(4), and designating information kept in the register as public for the purposes of subsection 23(4) that may be withheld from the public for the purposes of subsection 23(5);”

**The Chair:** Any discussion? I’ll call the vote, then. Those in favour of the motion? Opposed? It is carried.

Shall schedule M, section 73, as amended, carry? Carried.

Shall schedule M, sections 74 and 75, carry? Carried.

Shall schedule M, as amended, carry? Carried.

That moves us now to schedule N. Shall schedule N, sections 1 to 6, carry? Carried.

Shall schedule N carry? Carried.

Shall schedule O, sections 1 to 16, carry? Carried.

Shall schedule O carry? Carried.

Shall schedule P, sections 1 to 3, carry? Carried.

That brings us to schedule P, section 4. We have PC motion 83.

**Mrs. Witmer:** I guess there are going to be lots of changes made here. I’m just going to read it into the record.

I move that paragraph 5 of subsection 4(1) of schedule P to the bill be struck out and the following substituted:

“5. Communicating a diagnosis subject to the limit that the diagnoses that can be communicated are those which are reached through considering the individual’s history, the findings of a comprehensive health examination, and where necessary, the results of laboratory tests and other investigations that the member is authorized to perform, and are reached after complying with mandatory indicators for referral and consultation developed by the college.”

Obviously, this comes from the Board of Directors of Drugless Therapy. There was a concern that in the future the current wording would be interpreted to restrict the scope of naturopathic practice. We therefore recommend that the section be struck out and substituted with the wording that I have provided.

**The Chair:** Discussion?

**Mr. Fonseca:** We will not be supporting this motion because the government will be bringing forward a motion to split the colleges.

**The Chair:** Any other discussion? I will call the vote. Those in favour of the motion? Opposed? The motion is lost.

Shall schedule P, section 4, carry? Carried.

Now we have a new section, which is PC motion 84.

**Mrs. Witmer:** Based on the fact that it appears that the Ontario Association of Naturopathic Doctors has worked out an arrangement with the government and the government is doing what both Ms. Martel and I are recommending—splitting of the college—I will withdraw this motion.

*Interjections.*

**The Chair:** We’re just chatting, trying to figure out what we’re doing. Any other discussion?

**The Clerk of the Committee (Mr. Trevor Day):** No, it wasn’t moved.

**The Chair:** It wasn’t moved? I’m very sorry.

**Mrs. Witmer:** No, I just withdrew it.

**The Chair:** You withdrew it.

**Mrs. Witmer:** Yes.

**The Chair:** Okay. Schedule P, section 5: That brings us to PC motion 85.

**Mrs. Witmer:** This motion, of course, speaks to the separation of the two colleges, the college of naturopaths and also now the college of homeopaths. Again, since the government has a motion to do exactly that, I’ll withdraw this motion.

**The Chair:** Thank you.

Shall schedule P, section 5, carry? Carried.

We’re now at schedule P, section 6, with PC motion 86.

**Mrs. Witmer:** Again, I would withdraw that based on the separation of the two colleges—the motion coming forward from the government.

**The Chair:** Thank you.

Shall schedule P, section 6, carry? Carried.

Shall schedule P, section 7, carry? Carried.

Bringing us next to schedule P, section 8, PC motion 87.

**Mrs. Witmer:** Likewise, I'll withdraw this one, based on the arrangement the government's made with the two associations.

**The Chair:** Okay.

Shall schedule P, section 8, carry? Carried.

Shall schedule P, sections 9 and 10, carry? Carried.

That brings us to schedule P, section 11, PC motion 88.

**Mrs. Witmer:** Likewise, I'll withdraw that motion.

**The Chair:** Thank you.

Shall schedule P, section 11, carry? Carried.

Schedule P, section 12: PC motion 89.

**Mrs. Witmer:** Likewise, I'll withdraw that motion.

**The Chair:** And PC motion 90.

**Mrs. Witmer:** I will also withdraw that one.

*Interjection.*

**The Chair:** We're actually ahead of Trevor, if you'd just give us a minute.

**Mrs. Witmer:** Oh, I'm not surprised.

**The Chair:** No, it's not the first time.

Shall schedule P, section 12, carry? Carried.

Shall schedule P, sections 13 to 19, carry? Carried.

**The Chair:** We're now at schedule P, section 20: PC motion 91.

**Mrs. Witmer:** Likewise, I'm going to withdraw this since we're going to have a new section P eventually.

**The Chair:** Shall schedule P, section 20, carry? Carried.

Shall schedule P, sections 21 and 22, carry? Carried.

Now for schedule P, we have NDP motion 92.

**Ms. Martel:** Chair, both myself and the government have moved amendments so we have the creation of two separate colleges, one for naturopathic medicines and one for homeopaths. Now, my understanding is that if I read this in and the government votes it down because there are two areas where there are differences, the government's going to have to read theirs in again too, right? So I'm going to save us a little bit of time—I'm tempted, but I'm going to save us some—and withdraw mine, and I'll make my comments about my concerns with the government amendment after theirs is moved.

**The Chair:** I think I love you.

**Ms. Martel:** You're welcome. You can send me a cheque. For money I will—

*Interjection.*

**Ms. Martel:** I'll put in an application, though.

**The Chair:** That moves us to government motion 93. If anyone wishes to go for coffee or lunch or anything, this is probably the ideal time.

**Mr. Bob Delaney (Mississauga West):** Thank you, Chair.

**The Chair:** There's no such thing as "dispense" at committee level, I understand.

**Mr. Delaney:** I move that schedule P to the bill be struck out and the following substituted:

"Schedule P

"Naturopathy Act, 2007

"Definitions

"1. In this act,

"college" means the College of Naturopaths of Ontario; ("Ordre")

"Health Professions Procedural Code" means the Health Professions Procedural Code set out in schedule 2 to the Regulated Health Professions Act, 1991; ("Code des professions de la santé")

"member" means a member of the college; ('membre')

"prescribed" means prescribed in the regulations; ('prescrit')

"profession" means the profession of naturopathy; ('profession')

"this act" includes the Health Professions Procedural Code. ('la présente loi')

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"Health Professions Procedural Code

"2. (1) The Health Professions Procedural Code shall be deemed to be part of this act.

"Same, interpretation

"(2) In the Health Professions Procedural Code, as it applies in respect of this act,

"college" means the College of Naturopaths of Ontario; ('ordre')

"health profession act" means this act; ('loi sur une profession de la santé')

"profession" means the profession of naturopathy; ('profession')

"regulations" means the regulations under this act. ('règlements')

"Definitions in code

"(3) Definitions in the Health Professions Procedural Code apply with necessary modifications to terms in this act.

"Scope of practice

"3. The practice of naturopathy is the assessment of diseases, disorders and dysfunctions and the naturopathic diagnosis and treatment of diseases, disorders and dysfunctions using naturopathic techniques to promote, maintain or restore health.

"Authorized acts

"4. (1) In the course of engaging in the practice of naturopathy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

"1. Putting an instrument, hand or finger beyond the labia majora but not beyond the cervix.

"2. Putting an instrument, hand or finger beyond the anal verge but not beyond the rectal-sigmoidal junction.

"3. Administering, by injection or inhalation, a prescribed substance.

"4. Performing prescribed procedures involving moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

"5. Communicating a naturopathic diagnosis identifying, as the cause of an individual's symptoms, a disease, disorder or dysfunction that may be identified through an assessment that uses naturopathic techniques.



"6. Taking blood samples from veins or by skin pricking for the purpose of prescribed naturopathic examinations on the samples.

"Additional requirements for authorized acts

"(2) A member shall not perform a procedure under the authority of subsection (1) unless the member performs the procedure in accordance with the regulations.

"Grounds for misconduct

"(3) In addition to the grounds set out in subsection 51(1) of the Health Professions Procedural Code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (2).

"College established

"5. The college is established under the name College of Naturopaths of Ontario in English and Ordre des naturopathes de l'Ontario in French.

"Council

"6. (1) The council shall be composed of,

"(a) at least six and no more than nine persons who are members elected in accordance with the bylaws;

"(b) at least five and no more than eight persons appointed by the Lieutenant Governor in Council who are not,

"(i) members,

"(ii) members of a college as defined in the Regulated Health Professions Act, 1991, or

"(iii) members of a council as defined in the Regulated Health Professions Act, 1991.

"Who can vote in elections

"(2) Subject to the bylaws, every member who practises or resides in Ontario and who is not in default of payment of the annual membership fee is entitled to vote in an election of members of the council.

"President and vice-president

"7. The council shall have a president and a vice-president who shall be elected annually by the council from among the council's members.

"Restricted titles

"8. (1) No person other than a member shall use the title 'naturopath', a variation or abbreviation or an equivalent in another language.

"Representations of qualification, etc.

"(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a naturopath or in a specialty of naturopathy.

"Definition

"(3) In this section,

"'abbreviation' includes an abbreviation of a variation.

"Notice if suggestions referred to advisory council

"9. (1) The registrar shall give a notice to each member if the minister refers to the advisory council, as defined in the Regulated Health Professions Act, 1991, a suggested,

"(a) amendment to this act;

"(b) amendment to a regulation made by the council;

or

"(c) regulation to be made by the council.

"Requirements re notice

"(2) A notice mentioned in subsection (1) shall set out the suggestion referred to the advisory council and the notice shall be given within 30 days after the council of the college receives the minister's notice of the suggestion.

"Offence

"10. Every person who contravenes subsection 8(1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence.

"Regulations

"11. Subject to the approval of the Lieutenant Governor in Council and with prior review by the minister, the council may make regulations,

"(a) prescribing standards of practice respecting the circumstances in which naturopaths shall make referrals to members of other regulated health professions;

"(b) prescribing therapies involving the practice of naturopathy, governing the use of prescribed therapies and prohibiting the use of therapies other than the prescribed therapies in the course of the practice of naturopathy;

"(c) governing the performance of a procedure under paragraphs 1 and 2 of subsection 4(1) and prescribing the purposes for which, or the circumstances in which, the procedure may be performed;

"(d) prescribing the substances that a member may administer by injection or inhalation for the purpose of paragraph 3 of subsection 4(1) and prescribing the purposes for which, or the circumstances in which, the prescribed substances may be administered;

"(e) prescribing procedures that may be performed under paragraph 4 of subsection 4(1), governing the performance of the procedures and prescribing the purposes for which, or the circumstances in which, the prescribed procedures may be performed and prohibiting the performance of procedures other than the prescribed procedures;

"(f) prescribing naturopathic examinations for the purposes of paragraph 6 of subsection 4(1), prescribing the purposes for which, or the circumstances in which, the prescribed naturopathic examinations may be performed and prohibiting the performance of examinations other than the prescribed naturopathic examinations.

"Transition before certain provisions in force

"12. (1) The Lieutenant Governor in Council may appoint a transitional council.

"Certain members

"(2) Without restricting the generality of subsection (1), the Lieutenant Governor in Council shall appoint as members of the transitional council every person who is a member of the board of directors of drugless therapy under the Drugless Practitioners Act on the day this section comes into force, and every person who subsequently becomes a member of that board, and may set their terms of office for the purposes of this act.

"Registrar

"(3) The Lieutenant Governor in Council may appoint a registrar who may do anything that the registrar may do under the Regulated Health Professions Act, 1991.

"Powers of transitional council and registrar

"(4) Before section 6 comes into force, the registrar, the transitional council and its employees and committees may do anything that is necessary or advisable for the implementation of this act and anything that the registrar, the council, and its employees and committees could do under this act.

"Same

"(5) Without limiting the generality of subsection (4), the transitional council and the registrar and the council's committees may accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

"Powers of the minister

"(6) The minister may,

"(a) review the transitional council's activities and require the transitional council to provide reports and information;

"(b) require the transitional council to make, amend or revoke a regulation under this act;

"(c) require the transitional council to do anything that, in the opinion of the minister, is necessary or advisable to carry out the intent of this act and the Regulated Health Professions Act, 1991.

"Transitional council to comply with minister's request

"(7) If the minister requires the transitional council to do anything under subsection (6), the transitional council shall, within the time and in the manner specified by the minister, comply with the requirement and submit a report.

"Regulations

"(8) If the minister requires the transitional council to make, amend or revoke a regulation under clause (6)(b) and the transitional council does not do so within 60 days, the Lieutenant Governor in Council may make, amend or revoke the regulation.

"Same

"(9) Subsection (8) does not give the Lieutenant Governor in Council authority to do anything that the transitional council does not have authority to do.

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"Expenses

"(10) The minister may pay the transitional council for expenses incurred in complying with a requirement under subsection (6).

"Transition after certain provisions in force

"13(1) After section 6 comes into force, the transitional council shall be the council of the college if it is constituted in accordance with subsection 6(1) or, if it is not, it shall be deemed to be the council of the college until a new council is constituted in accordance with subsection 6(1).

"Registrar

"(2) After section 6 comes into force, the registrar appointed by the Lieutenant Governor in Council shall be deemed to be the registrar until a new registrar is appointed by the council constituted under subsection 6(1).

"Transitional, certain members

"(3) A person who was registered to practise under the Drugless Practitioners Act by the board of directors of drugless therapy immediately before section 6 came into force shall be deemed to be a holder of a certificate of registration issued under this act, subject to any term, condition, limitation, suspension or cancellation to which the person's certificate of registration was subject.

"Same—investigation or discipline

"(4) Where, before section 6 comes into force, an investigation or proceeding respecting an allegation of misconduct, incompetence or other discipline matter was commenced under the Drugless Practitioners Act and its regulations by the board of directors of drugless therapy, on the day section 6 comes into force,

"(a) the investigation or proceeding shall be taken up and continued under this act so far as consistently may be;

"(b) the board of directors of drugless therapy, as it existed immediately before the coming into force of section 6, shall be deemed to be the appropriate committee under this act to deal with the investigation or proceeding until others are appointed in their stead; and

"(c) in the recovery or enforcement of penalties and in the enforcement of rights existing under the Drugless Practitioners Act, the procedure established under this act shall be followed so far as it may be adapted.

"Same—assets and liabilities

"(5) After section 6 comes into force, the assets owned by or under the management and control of, and the liabilities of the board of directors of drugless therapy under the Drugless Practitioners Act immediately before the coming into force are, without compensation, assets owned by or under the management and control and liabilities of the college.

"Complementary amendments and repeal

"Drugless Practitioners Act

"14(1) The Drugless Practitioners Act is repealed.

"(2) Regulation 278 of the Revised Regulations of Ontario, 1990 (General) is revoked.

"Health Care Consent Act, 1996

"15. Clause (s) of the definition of 'health practitioner' in subsection 2 (1) of the Health Care Consent Act, 1996 is repealed and the following substituted:

"(s) a member of the College of Naturopaths of Ontario, or'

"Health Insurance Act

"16. Subsection 37(4) of the Health Insurance Act is amended by striking out 'the Drugless Practitioners Act'.

"Health Protection and Promotion Act

"17. Clause (f) of the definition of 'practitioner' in subsection 25(2) of the Health Protection and Promotion Act is repealed and the following substituted:

"(f) a member of the College of Naturopaths of Ontario.'

"Laboratory and Specimen Collection Centre Licensing Act

"18. The definitions of 'laboratory' and 'specimen collection centre' in section 5 of the Laboratory and



Specimen Collection Centre Licensing Act are repealed and the following substituted:

““laboratory” means an institution, building or place in which operations and procedures for the microbiological, serological, chemical, hematological, biophysical, immunohematological, cytological, pathological, cytogenetic, molecular genetic or genetic examination, or such other examinations as are prescribed by the regulations, of specimens taken from the human body are performed to obtain information for medical diagnosis, prophylaxis or treatment; (“laboratoire”)

““specimen collection centre” means a place where specimens are taken or collected from the human body for examination to obtain information for medical diagnosis, prophylaxis or treatment, but does not include,

“(a) a place where a legally qualified medical practitioner is engaged in the practice of medicine or surgery,

“(b) a place where a registered nurse who holds an extended certificate of registration under the Nursing Act, 1991 is engaged in the practice of nursing, or

“(c) a laboratory that is established, operated or maintained under a licence under this act; (“centre de prélèvement”)

“Personal Health Information Protection Act, 2004

“19. Clause (b) of the definition of ‘health care practitioner’ in section 2 of the Personal Health Information Protection Act, 2004 is repealed.

“Regulated Health Professions Act, 1991

“20(1) Section 33 of the Regulated Health Professions Act, 1991 is amended by adding the following subsections:

“Same

“(1.1) Subsection (1) does not apply to a person who is a member of the College of Naturopaths of Ontario.

“Naturopathic doctor

“(1.2) A member referred to in subsection (1.1) shall not use the title “doctor” in written format without using the phrase “naturopathic doctor” immediately following his or her name.”

“(2) The table to the act is amended by adding the following item:

“7.1	person registered under the Drugless Practitioners Act	member of the College of Naturopaths of Ontario’
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“(3) Schedule 1 to the act is amended by adding the following:

“	Naturopathy Act, 2007	Naturopathy	”
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“Commencement

“21(1) Subject to subsection (2), the act set out in this schedule comes into force on the day the Health System Improvements Act, 2007 receives royal assent.

“Same

“(2) Sections 1 to 20 come into force on a day to be named by proclamation of the Lieutenant Governor.

“Short title

“22. The short title of the act set out in this schedule is the Naturopathy Act, 2007.”

**The Chair:** Sorry, I missed that. Would you mind repeating it?

*Laughter.*

**Mr. Delaney:** Certainly, Chair.

**The Chair:** Any discussion? Ms. Martel.

**Ms. Martel:** We had also put in an amendment to ensure that there would be a separate college, as per the request of naturopaths. I just wanted to put on the record the differences between the amendment that we put forward and the one that the government has put forward.

First of all, references to “college”: In our amendment, we used the term that was provided to us by naturopaths, which is the College of Naturopathic Doctors of Ontario, versus what the government has in the bill, which is College of Naturopaths of Ontario. That follows throughout the whole amendment, wherever the college is referenced. The wording we are using is the wording that was provided to us by the association.

Secondly, the same follows with respect to a profession. Our definition was “the profession of naturopathic medicine.” The government’s definition is “the profession of naturopathy.” Again, we’re using the wording that was given to us by the Ontario Association of Naturopathic Doctors.

The two major differences are as follows. One occurs within the scope of practice. I want to put on the record that the scope of practice that is the preferred scope of practice by the association itself, which was not accepted today, is the following, and it is the amendment that we put forward:

“Scope of practice

“3. The practice of naturopathic medicine is the assessment of an individual, and the diagnosis and treatment of diseases, disorders and dysfunctions through the integrated use of naturopathic techniques to promote, maintain or restore health.”

There is a bit of a difference in that around naturopathic medicine and naturopathy. Again, ours was the one put forward by the association.

Finally, with respect to authorized acts, the association had requested an additional authorized act, which the government has not accepted. It is the following and it is in our amendment:

“7. Prescribing, dispensing, selling or compounding prescribed substances that are consistent with the practice of naturopathic medicine.”

I’d like to put on the record the reason for that request from the association. It is the following:

“Access to this controlled act is necessary for naturopathic doctors ... to be able to maintain their current scope and to preserve access to required natural substances while federal classification of these substances continues to undergo changes.

“The change in schedule L of Bill 171 deeming that natural health products ... are not considered drugs is insufficient because this only addresses that subset of natural substances (natural health products) intended for

over-the-counter self-care selection by consumers. There are many natural substances traditionally used in naturopathic medicine that do not fall within the definition or purview of the natural health products regulations (such as higher doses of folic acid) or are presently listed in restricted schedules (i.e. schedule F), or are combination products cross-listed as drugs.

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"Compounding, as well as dispensing and selling, are necessary in order ... to provide the individualized preparations that are integral to naturopathic care.

"Access to this controlled act was recommended by HPRAC and is currently part of the scope of practice of NDs in Ontario under the Drugless Practitioners Act (DPA).

"NDs are prepared to work with the transition council to develop a schedule of natural substances designated as drugs suitable for use by NDs.

"Without this controlled act, NDs and their patients will lose access to natural substances that are currently available, effectively limiting the ability of NDs to practise to their full scope and likely resulting in a loss of care for patients."

Based on that rationalization, the NDP amendment also included an additional controlled act, that is, "Prescribing, dispensing, selling or compounding prescribed substances...." I think those are the differences between our amendment and the government amendment in this schedule.

**Mr. Fonseca:** I thank Ms. Martel for her comments. Our wording for communicating a diagnosis is consistent with the Traditional Chinese Medicine Act, and the changes that were brought to the TCM Act also allow naturopaths to continue to have access to those natural health products that they currently use.

**Mrs. Witmer:** I appreciate that the government did divide the colleges into two. I had some of the same recommendations that Ms. Martel has just spoken to. I won't repeat them, but this is a positive move forward.

**The Chair:** If there's no more discussion, I will call the vote.

Those in favour of the amendments? Those opposed? It is carried.

Shall schedule P, as amended, carry? It is carried.

We have a new schedule, NDP motion 94.

**Ms. Martel:** I believe that the differences between the amendment I'm putting forward and the one the government is putting forward to establish a separate Homeopathy Act and a separate college are essentially the same. When the government has read in its motion, I will speak to the differences at that time. So I will withdraw my amendment to this schedule.

**The Chair:** That brings us to the new schedule, government motion 95.

**Mr. Delaney:** I move that the bill be amended by adding the following schedule:

"Schedule P.1

"Homeopathy Act, 2007

"Definitions

"1. In this act,

"college" means the College of Homeopaths of Ontario; ('Ordre')

"Health Professions Procedural Code" means the Health Professions Procedural Code set out in schedule 2 to the Regulated Health Professions Act, 1991; ('Code des professions de la santé')

"member" means a member of the college; ('membre')

"prescribed" means prescribed in the regulations; ('prescrit')

"profession" means the profession of homeopathy; ('profession')

"this act" includes the Health Professions Procedural Code. ('la présente loi')

"Health Professions Procedural Code

"2(1) The Health Professions Procedural Code shall be deemed to be part of this act.

"Same, interpretation

"(2) In the Health Professions Procedural Code, as it applies in respect of this act,

"college" means the College of Homeopaths of Ontario; ('ordre')

"health profession act" means this act; ('loi sur une profession de la santé')

"profession" means the profession of homeopathy; ('profession')

"regulations" means the regulations under this act. ('rèlements')

"Definitions in code

"(3) Definitions in the Health Professions Procedural Code apply with necessary modifications to terms in this act.

"Scope of practice

"3. The practice of homeopathy is the assessment of body system disorders and treatment using homeopathic techniques to promote, maintain or restore health.

"College established

"4. The college is established under the name College of Homeopaths of Ontario in English and Ordre des homéopathes de l'Ontario in French.

"Council

"5(1) The council shall be composed of,

"(a) at least six and no more than nine persons who are members elected in accordance with the by-laws;

"(b) at least five and no more than eight persons appointed by the Lieutenant Governor in Council who are not,

"(i) members,

"(ii) members of a college as defined in the Regulated Health Professions Act, 1991, or

"(iii) members of a council as defined in the Regulated Health Professions Act, 1991.

"Who can vote in elections

"(2) Subject to the by-laws, every member who practises or resides in Ontario and who is not in default of payment of the annual membership fee is entitled to vote in an election of members of the council.

"President and vice-president



"6. The council shall have a president and a vice-president who shall be elected annually by the council from among the council's members.

"Restricted titles

"7(1) No person other than a member shall use the title 'homeopath,' a variation or abbreviation or an equivalent in another language.

"Representations of qualification, etc.

"(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a homeopath or in a specialty of homeopathy.

"Definition

"(3) In this section,

"'abbreviation' includes an abbreviation of a variation.

"Notice if suggestions referred to advisory council

"8(1) The registrar shall give a notice to each member if the minister refers to the advisory council, as defined in the Regulated Health Professions Act, 1991, a suggested,

"(a) amendment to this act;

"(b) amendment to a regulation made by the council;

or  
 "(c) regulation to be made by the council.

"Requirements re notice

"(2) A notice mentioned in subsection (1) shall set out the suggestion referred to the advisory council and the notice shall be given within 30 days after the council of the college receives the minister's notice of the suggestion.

"Offence

"9. Every person who contravenes subsection 7(1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence.

"Regulations

"10. Subject to the approval of the Lieutenant Governor in Council and with prior review by the minister, the council may make regulations,

"(a) prescribing standards of practice respecting the circumstances in which homeopaths shall make referrals to members of other regulated health professions;

"(b) prescribing therapies involving the practice of homeopathy, governing the use of the prescribed therapies and prohibiting the use of therapies other than the prescribed therapies in the course of the practice of homeopathy.

"Transition before certain provisions in force

"11(1) The Lieutenant Governor in Council may appoint a transitional council.

"Registrar

"(2) The Lieutenant Governor in Council may appoint a registrar who may do anything that the registrar may do under the Regulated Health Professions Act, 1991.

"Powers of transitional council and registrar

"(3) Before section 5 comes into force, the registrar, the transitional council and its employees and committees may do anything that is necessary or advisable for the implementation of this act and anything that the registrar, the council, and its employees and committees could do under this act.

"Same

"(4) Without limiting the generality of subsection (3), the transitional council and the registrar and the council's committees may accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

"Powers of the minister

"(5) The minister may,

"(a) review the transitional council's activities and require the transitional council to provide reports and information;

"(b) require the transitional council to make, amend or revoke a regulation under this act;

"(c) require the transitional council to do anything that, in the opinion of the minister, is necessary or advisable to carry out the intent of this act and the Regulated Health Professions Act, 1991.

"Transitional council to comply with minister's request

"(6) If the minister requires the transitional council to do anything under subsection (5), the transitional council shall, within the time and in the manner specified by the minister, comply with the requirement and submit a report.

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"Regulations

"(7) If the minister requires the transitional council to make, amend or revoke a regulation under clause (5)(b) and the transitional council does not do so within 60 days, the Lieutenant Governor in Council may make, amend or revoke the regulation.

"Same

"(8) Subsection (7) does not give the Lieutenant Governor in Council authority to do anything that the transitional council does not have authority to do.

"Expenses

"(9) The minister may pay the transitional council for expenses incurred in complying with a requirement under subsection (5).

"Transition after certain provisions in force

"12. (1) After section 5 comes into force, the transitional council shall be the council of the college if it is constituted in accordance with subsection 5(1) or, if it is not, it shall be deemed to be the council of the college until a new council is constituted in accordance with subsection 5(1).

"Registrar

"(2) After section 5 comes into force, the registrar appointed by the Lieutenant Governor in Council shall be deemed to be the registrar until a new registrar is appointed by the council constituted under subsection 5(1).

"Complementary amendments

"Health Care Consent Act, 1996

"13. The definition of 'health practitioner' in subsection 2(1) of the Health Care Consent Act, 1996 is amended by adding the following clause:

"(g.1) a member of the College of Homeopaths of Ontario,"

"Regulated Health Professions Act, 1991

"14. Schedule 1 to the Regulated Health Professions Act, 1991 is amended by adding the following:

" " Homeopathy Act, 2007 Homeopathy " "

"Commencement

"15(1) Subject to subsection (2), the act set out in this schedule comes into force on the day the Health System Improvements Act, 2007 receives royal assent.

"Same

"(2) Sections 3 to 10 and 12 to 14 come into force on a day to be named by proclamation of the Lieutenant Governor.

"Short title

"16. The short title of the act set out in this schedule is the Homeopathy Act, 2007."

**The Chair:** Thank you. Discussion?

**Ms. Martel:** Both the government and New Democrats put in amendments to have a separate college, based on the presentations that were made before us, so I'm pleased to see that we're moving in that regard.

The two areas of differences are ones that I just want to highlight on the record. The first is, we had a different definition of "scope of practice" and we also had controlled acts included in the legislation that were recommended to us by the Ontario Homeopathic Association. So I'd like to put some of these on the record.

First of all, with respect to the scope of practice, the definition that was put forward in the NDP amendment is as follows: "The practice of homeopathy is the assessment of an individual's state of health based on homeopathic techniques in accordance with the law of similars and other homeopathic principles and identification of appropriate homeopathic medicines, techniques and natural substances to restore, maintain and promote health on physical, mental and emotional levels." That was recommended to us by the Ontario Homeopathic Association, and that is the difference between our amendment and the government's.

The second has to do with access to controlled acts. The government does not give college members in this schedule access to any controlled acts. New Democrats had proposed that homeopaths have access to three controlled acts. They are as follows.

First of all, communicating a diagnosis: In its initial submission to HPRAC, the Ontario Homeopathic Association noted that diagnosis was "a vital and fundamental aspect of the homeopathic system of medicine. A homeopathic diagnosis is based on a patient's physical, mental and emotional condition, objective and subjective symptomology, history, diagnostic test results and physical examination findings. An accurate homeopathic diagnosis is necessary to prescribe the correct homeopathic medicine and to identify and discuss treatment and conditions, including those that require urgent emergency medical treatment."

The second controlled act that we recommended be provided to members is as follows.

"Administering, by injection or inhalation, a prescribed substance: Traditionally, homeopathic medicines were administered orally. However, scientific research being conducted in a number of medical centres in Europe has established that some homeopathic remedies are more effectively administered by injection. Based on that research, it is standard homeopathic practice in some jurisdictions to administer some homeopathic remedies by injection. Permitting a homeopath to perform the controlled act of administering a prescribed homeopathic substance by injection or inhalation in accordance with the appropriate regulations is in the public interest. This will allow the most effective homeopathic treatment under prescribed conditions that protect the public."

The third controlled act that was put forward in the amendment by the NDP is prescribing, dispensing, selling or compounding a drug as defined in subsection 117(1) of the Drug and Pharmacies Regulation Act.

"Most homeopathic medications used in the practice of homeopathy in Ontario are defined as 'natural health products' pursuant to the Natural Health Products Regulations made under the Food and Drugs Act ('Regulations'). This means they are not considered to be drugs as defined in the Drug and Pharmacies Regulation Act and homeopaths can prescribe, dispense, sell or compound them. However, there are some homeopathic medications contained in the accepted homeopathic pharmacopoeias which are not defined as natural health products. Homeopaths in Ontario cannot legally use these homeopathic medications in the practice of homeopathy because, absent being defined as 'natural health products,' they are defined as drugs. It is a controlled act to prescribe, dispense or sell a drug.

"In order to ensure that homeopaths and homeopathic patients in Ontario can benefit from the full range of homeopathic medications in the homeopathic pharmacopoeia, homeopaths require the authority to perform the controlled act of prescribing, dispensing, selling and compounding homeopathic medicines."

Those were the three controlled acts that we moved should be accessed by homeopaths when the college is established. These were put forward on behalf of the Ontario Homeopathic Association.

**Mr. Fonseca:** Just to be clear, HPRAC did not recommend any of the controlled acts, and in regards to injections, homeopaths today don't currently do this. They are not injecting today.

**Mrs. Witmer:** Just to put on the record, I won't go into all of the amendments that we introduced, but certainly we support the separation of the college and had an amendment to that effect.

**The Chair:** If there's no other discussion, I will call the vote. Those in favour of the amendment? Opposed? It is carried.

We're now at schedule Q, section 1, NDP motion number 96.

**Ms. Martel:** I move that the definition of "college" in section 1 of schedule Q to the bill be struck out and the following substituted:



“college” means the College of Psychotherapists and Registered Mental Health Therapists of Ontario;”

**The Chair:** Discussion? I call the motion. Those in favour? Opposed? It is carried.

Shall schedule Q, section 1, as amended, carry? It is carried.

Schedule Q, section 2, NDP motion 97.

**Ms. Martel:** I move that the definition of “college” in subsection 2(2) of schedule Q to the bill be struck out and the following substituted:

“college” means the College of Psychotherapists and Registered Mental Health Therapists of Ontario;”

**The Chair:** Those in favour? Opposed? It is carried.

Shall schedule Q, section 2, as amended, carry? Carried.

Shall schedule Q, sections 3 and 4, carry? Carried.

That brings us to a new section: NDP motion number 98.

**Ms. Martel:** I move that schedule—

**Mr. Delaney:** It’s a PC motion.

**The Chair:** I’m sorry. My mistake. I do that once in a while to see if people are paying attention. PC motion 98.

**Mrs. Witmer:** I move that schedule Q to the bill be amended by adding the following section:

“Restricted classes

“4.1 The council shall create one additional class of psychotherapists and one additional class of mental health therapists, who shall not perform the act provided for in section 4, and who shall perform certain acts, as provided for by the council, only under the supervision of a fully qualified member.”

The Ontario Psychological Association has indicated that experiences from the implementation of the Psychology Act, 1991 provide evidence that “a differentiation can be made between a title and a class, and unless classes are defined in the enabling legislation, classes of membership cannot later be assumed simply because the titles of the members differ. Without a definition in the Psychotherapy Act, 2006 of classes of membership, neither class limitations nor terms or conditions can be imposed.

“The Ontario Psychological Association would argue, however that the new college will need to impose class limitations, because of the substantial heterogeneity of individuals seeking entry to the proposed college.

“The Ontario Psychological Association is supportive of the potential substantive heterogeneity of members of the proposed college and its potential to ensure public protection by bringing as many as possible of these health care professionals into a regulatory framework.”

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It has also been brought to my attention that the National Guild of Hypnotists are concerned that the proposed definition of the practice of psychotherapy, as set out in section 3 of schedule Q, will limit the boundaries of the National Guild of Hypnotists to practise non-therapeutic use such as time management, sports enhancement, self-esteem and performance improvement.

**The Chair:** Any other discussion?

**Mr. Fonseca:** First, on the motion: This motion would require the college to establish certain classes of members and place restrictions on those classes, in terms of access to the new controlled act related to psychotherapy. The government doesn’t support this motion because it restricts the college’s discretion in terms of how it regulates its members and the profession.

In regard to the hypnotists, Bill 171 is not here to address that. If it did become an issue and we needed expertise on it, it would be referred to HPRAC.

**The Chair:** Additional discussion? I’ll call the vote. Those in favour of the amendment? Opposed? The motion is lost.

Schedule Q, section 5: Now we have NDP amendment 99R.

**Ms. Martel:** I move that section 5 of schedule Q to the bill be amended by adding “and registered mental health therapists” after “psychotherapists” and “et des thérapeutes autorisés en santé mentale” after “psychothérapeutes”.

**The Chair:** Discussion? I will call the vote. Those in favour of the motion? Those opposed? The motion is carried.

Shall schedule Q, section 5, as amended, carry? Carried.

Shall schedule Q, sections 6 and 7, carry? Carried.

That brings us to schedule Q, section 8. The first amendment is PC motion number 100.

**Mrs. Witmer:** I move that subsection 8(1) of schedule Q to the bill be amended by adding “or any specialty subtitle established by the college before ‘a variation’.”

This was from the written submission of the Ontario Association for Marriage and Family Therapy. It was presented by Dr. Ruth Berman, who believes that subtitles may assist individuals, couples and families on various occasions to navigate the health system when trying to find the most appropriate specialist in the psychotherapy profession. There is importance for individuals, couples and families to access the practitioner who most closely matches their need at any particular moment. It is therefore recommended that the college be given the express consent to establish specialty subtitles.

**The Chair:** Any additional discussion?

**Mr. Delaney:** Just a clarification question on what is, I think, perhaps a typographic omission: Is it the intent that there be a closed quotes after the words “by the college”?

**Mrs. Witmer:** I believe there probably should be.

**Mr. Delaney:** Thank you.

**Mr. Fonseca:** I’d just like to say that the government does not support this motion because it restricts the college’s discretion in terms of how it regulates its members and the profession. Also, the transitional council may use this regulation-making authority to create different classes of members with particular titles.

**The Chair:** I will call the vote. Those in favour of the motion? Opposed? The motion is lost.

That brings us to PC motion 101.

**Mrs. Witmer:** I move that subsection 8(1) of schedule Q to the bill be amended by adding "or a member of a regulated health profession who is entitled to perform the controlled act of psychotherapy" after "member".

Again, this was brought forward by the College of Physicians and Surgeons of Ontario. This is their recommendation.

**The Chair:** Discussion?

**Mr. Fonseca:** The government does not support this motion because it would extend the use of the title "psychotherapist" to members of other health-regulated colleges. The use of restricted titles is one of the key public protection features of the RHPA.

**The Chair:** I'll call the vote. Those in favour of the motion? Opposed? The motion is lost.

That brings us to PC motion 102.

**Mrs. Witmer:** I move that section 8 of schedule Q to the bill be amended by adding the following subsection:

"Exception

"(1.1) Despite subsection (1), a member of the Ontario College of Social Workers and Social Service Workers may use the title 'psychotherapist' as long as he or she does so in conjunction with the title 'social worker' or 'registered social worker'."

This was recommended by the Ontario College of Social Workers and Social Service Workers in their written submission: "The title restriction provision set out in the Psychotherapy Act will prevent social workers who are qualified to provide psychotherapy services from using the title 'psychotherapist' or 'registered mental health therapist.'" That was their concern, of course, at that time. "The holding out provision set out in the Psychotherapy Act will prevent a social worker from representing to members of the public that he or she is qualified to practise in Ontario as a psychotherapist... HPRAC recommended that social workers ... be authorized to use the title 'psychotherapist.' HPRAC also recommended that social workers ... be authorized to represent that they are qualified to practise psychotherapy in Ontario." The OCSWSSW believes this will "be confusing to members of the public if those who are qualified to provide psychotherapy services cannot continue to describe themselves as 'psychotherapists.'" That was the argument that they had put forward in their submission of April 2007.

**The Chair:** Any other discussion? I will call the vote. Those in favour of the amendment? Opposed? The amendment is lost.

That brings us to NDP motion 103.

**Ms. Martel:** I move that section 8 of schedule Q to the bill be amended by adding the following subsection:

"Others

"(1.1) Despite subsection (1), any person who may lawfully perform the act provided for in section 4 may use a title set out in subsection (1)."

I've heard some of the arguments that have been raised, but I want to point that this particular amendment is supported by the following: the Ontario Society of

Occupational Therapists, the Ontario Medical Association, the Ontario Psychological Association, and the Registered Nurses Association of Ontario. We strongly recommend that those regulated professions authorized to carry out the new controlled act also be authorized use the proposed protected titles.

**The Chair:** Discussion? I'll call the vote. Those in favour of the motion? Opposed? It is lost.

PC motion 104.

**Mrs. Witmer:** I move that section 8 of schedule Q to the bill be amended by adding the following subsection:

"Exception

"(2.1) Subsection (2) does not apply to a member of the Ontario College of Social Workers and Social Service Workers as long as he or she complies with the Social Work and Social Service Work Act, 1998, its regulations and bylaws."

Again, this is taken from the Ontario College of Social Workers and Social Service Workers' submission. The proposed legislation, as originally drafted, will have a serious impact on Ontarians who currently receive psychotherapy services from the province's social workers, considering that psychotherapy services are currently provided by social workers in Ontario, that social work is the largest single discipline providing psychotherapy services in North America and that psychotherapy services in the area of adult mental health, children's mental health, marital, family and individual counselling, addictions, child welfare and hospitals are largely provided by social workers.

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**The Chair:** Any other discussion?

**Mr. Fonseca:** Nothing today prevents social workers from holding themselves out as social workers who provide psychotherapy services.

**The Chair:** If there's no other discussion, I will call the vote: Those in favour of the motion? Those opposed? It is lost.

PC motion 105.

**Mrs. Witmer:** I move that section 8 of schedule Q to the bill be amended by adding the following subsection:

"Exception

"(2.2) Subsections (1) and (2) do not apply to a member of a regulated health profession who is authorized to perform the authorized act provided for in section 4."

Again, this is from the Ontario College of Social Workers and Social Service Workers. The college believes the adding is necessary to ensure that the legislation authorizes social workers to continue to provide psychotherapy services, recognizes the psychotherapy services provided by social workers and treats social workers on an equal footing to regulated health professionals, as well as to ensure that social workers who provide psychotherapy services associated with the new controlled act will continue to be able to provide these important services in Ontario.

**The Chair:** Other discussion? Those in favour of the motion? Those opposed? It is lost.

NDP motion 106.



**Ms. Martel:** I move that section 8 of schedule Q to the bill be amended by adding the following subsection:

“Specialty subtitles

“(4) Specialty subtitles shall be designated under the protected titles of ‘psychotherapist’ and ‘registered mental health therapist’.”

**The Chair:** Any discussion?

**Ms. Martel:** Yes. This was put forward by the Ontario Coalition of Mental Health Professionals, and I just want to put on the record their concerns with respect to this section and why they wanted it moved in the Regulated Health Professions Act.

Section 95(1)(e) states that the council may make regulations “defining specialties in the profession, providing for certificates relating to those specialties, the qualifications for and suspension and revocation of those certificates and governing the use of prescribed terms, titles or designations by members indicating a specialization in the profession.”

The coalition wants to go beyond the authorization in the Regulated Health Professions Act, which leaves it open to council not to have specialty subtitles. This is a very big issue for some of the coalition partners, especially the marriage and family therapists who are regulated all over the United States and in Quebec as a distinct profession.

I would also point out that we certainly do have a concern about peer counsellors. I think that was made clear with respect to the presentation by the federation, and this would ensure that there do have to be designations.

**The Chair:** Discussion?

**Mr. Fonseca:** Colleges have the ability to make these classes, and we feel that we shouldn’t be forcing them.

**The Chair:** If there’s no other discussion, I will call the vote. Those in favour of the motion? Those opposed? It is lost.

I will now ask, shall schedule Q, section 8, carry? Carried.

Shall schedule Q, sections 9 and 10, carry? Carried.

Moving us to schedule Q, section 11, PC motion number 107.

**Mrs. Witmer:** I move that section 11 of schedule Q to the bill be amended by adding the following subsection:

“Consultation

“(2) The council shall not make a regulation under subsection (1) unless it has first consulted with other colleges whose members provide psychotherapy services.”

The supporting argument for this comes again from the Ontario College of Social Workers and Social Service Workers. They believe that the regulation authority under section 11 means that the nature of the practice of psychotherapy may be further delineated through regulations made under the Psychotherapy Act. The college believes there is no formal mechanism for other regulated professions who may be impacted by these regulations and may have important comments to make regarding them to participate in the process. Therefore, the college believes that a consultation process prior to regulations

being made under section 11 of the Psychotherapy Act, 2006, would inform any such regulations and promote consistency with respect to the delivery of psychotherapy services. The college notes that there is a precedent for a consultation process for regulations being required by legislation.

**The Chair:** Other discussion?

**Mr. Fonseca:** The government does not support this motion, because colleges are already expected to consult with all relevant stakeholders when making any regulations and, further, all regulations proposed by colleges are reviewed by the minister and require government approval.

**The Chair:** I will call the vote.

Those in favour of the motion? Opposed? It is lost.

Shall schedule Q, section 11 carry? Carried.

Shall schedule Q, sections 12 and 13 carry? Carried.

That brings us to schedule Q, section 14: NDP amendment 108.

**Ms. Martel:** I move that clause (q.1) of the definition of “health care practitioner” as set out in section 14 of Schedule Q to the bill, be amended by adding “and registered mental health therapists” after “psychotherapists”.

**The Chair:** I will call the vote.

Those in favour of the amendment? Opposed? It carries.

Shall schedule Q, section 14, as amended, carry? Carried.

Shall schedule Q, sections 15 to 18 carry? Carried.

That brings us to schedule Q, section 19: NDP motion 109.

**Ms. Martel:** I move that section 19 of schedule Q to the bill be amended by adding the following subsection:

“(1.1) Section 27 of the act is amended by adding the following subsection:

““Social workers

“(2.1) Subsection (1) as it relates to paragraph 14 of subsection (2) and the Psychotherapy Act, 2007 do not apply to a member of the Ontario College of Social Workers and Social Service Workers who is in compliance with the Social Work and Social Service Work Act, 1998, its regulations and by-laws, and for greater certainty, such a member is authorized to perform the controlled act set out in paragraph 14 of subsection (2).”

This amendment was given to the committee by the Ontario Association of Social Workers as their preferred method to be included in the bill, particularly under schedule Q.

**The Chair:** Any other discussion?

**Mr. Fonseca:** I ask that we look at motions 109, 110 and 111 together, because our wording has support from the social workers and the college association. I’d also like to read into the record that on May 7, 2007, Dan Andreae, president of the Ontario Association of Social Workers, said: “I wish to commend the Minister of Health and Long-Term Care for his exemplary work in preparing and introducing a key and necessary amend-

ment to Bill 171 that authorizes social work to perform the controlled act of psychotherapy.”

**The Chair:** Appreciate that we can't consider three motions.

**Mrs. Witmer:** I'm sorry. Could you go back to the first part? I was in conversation.

**Mr. Fonseca:** That we look at 109, 110 and 111 together, because it is addressed by the government in 111—our wording has been supported by the social workers and the college association.

**The Chair:** The only options available are to vote on this motion or withdraw it.

**Ms. Martel:** Chair, I'm assuming that we're all working to the same end here, so I will withdraw my amendment.

**The Chair:** Motion 109 has been withdrawn. We have PC motion 110.

**Mrs. Witmer:** If the government has assured me that Dr. Andreae is happy with motion 111, then I would withdraw motion 110. It really was to ensure that they be allowed to perform this controlled act.

**The Chair:** That brings us to government motion 111.

**Mr. Fonseca:** I move that section 19 of Schedule Q to the bill be amended by adding the following subsection:

“(1.1) Section 27 of the act is amended by adding the following subsection:

“Same

“(4) Despite subsection (1), a member of the Ontario College of Social Workers and Social Service Workers is authorized to perform the controlled act set out in paragraph 14 of subsection (2), in compliance with the Social Work and Social Service Work Act, 1998, its regulations and by-laws.”

**The Chair:** Any discussion?

**Mrs. Witmer:** I think this was an omission that has now been addressed. But if we take a look at the fact social work is the largest single discipline providing psychotherapy services in North America, and when you take a look at the psychotherapy services that it provides in so many areas—adult mental health, children's mental health, marital, family, addictions, etc.—certainly it is important that social workers continue to be included in the provision of psychotherapy services.

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**The Chair:** Any other discussion? I will call the vote. Those in favour of the motion? Opposed? It is carried.

That brings us to PC motion number 112.

**Mrs. Witmer:** I move that section 19 of schedule Q to the bill be amended by adding the following subsection:

“(1.1) Section 33 of the act is amended by adding the following subsection:

““Exception

“(2.1) Subsection (1) does not apply with respect to a member of the Ontario College of Social Workers and Social Service Workers who holds the title “doctor”.”

This—

**The Chair:** Before you proceed, I have to rule this is out of order. Section 33 is not open. You could ask for unanimous consent.

**Mrs. Witmer:** I'd like to ask for unanimous consent.

**The Chair:** Is there unanimous consent? Agreed.

**Mrs. Witmer:** Thank you very much. This is an issue of concern and interest, particularly to the Ontario Social Work Doctors' Colloquium. When universities today confer doctoral degrees, they do not qualify or limit how the recipients are going to use that title. The Social Work Doctors' Colloquium believes that by imposing restrictions on where and how the title can be used, the RHPA contravenes the legislation that authorizes universities to grant doctoral degrees, considering this restriction is specific to Ontario, with no other jurisdiction in Canada, the United States, the United Kingdom, Australia or New Zealand having such restrictions.

As well, the colloquium believes that by imposing the restriction on the use of the title, the entire profession is devalued. Considering that a profession whose practice for over a century has been integral to the provision of health services in Ontario in such areas as hospitals, prisons, psychiatric facilities, mental health clinics, homes for the aged, child welfare and family agencies and disability services, I would really strongly recommend that all of my colleagues consider and support this amendment regarding the doctor title for these individuals.

**Mr. Fonseca:** At this time we're still reviewing the HPRAC recommendations on this issue. We're not prepared to move on this at this time. We believe that consultation is still required. This bill still accomplishes quite a lot, and we feel that the professionals and patients will benefit from Bill 171.

**Mrs. Witmer:** Might I ask the government, then, if they are giving serious consideration to this issue of the “doctor” title or is this just an attempt to limit the discussion today? Will you be continuing the dialogue with these social workers?

**Mr. Fonseca:** Yes, we will.

**Mrs. Witmer:** So there is a very strong possibility that this amendment may well yet come into fruition?

**Mr. Fonseca:** Not under this legislation, no.

**Mrs. Witmer:** Okay. I see the minister's representative, who is here today, shaking his head. So you're saying there will be no consideration given to this issue of the “doctor” title for social workers?

**Mr. Fonseca:** It is under consultation now, but not as part of Bill 171.

**Mrs. Witmer:** Right, but you are considering doing it or—I see the minister's person shaking his head no.

**Mr. Fonseca:** HPRAC continues to review it.

**Mrs. Witmer:** I hope the government really would give very serious consideration. This restriction is only specific to Ontario. If you go anywhere else in Canada, if you go to the United States, the United Kingdom, Australia or New Zealand, there is no restriction on the use of the title as we currently have it in the province of Ontario. I hope we will respect social workers and grant them this request. Thank you very much for your consideration.

**Ms. Martel:** I support the motion that's been put forward by Ms. Witmer and I have motions that follow that are similar in terms of trying to arrive at the same



intent around the use of the “doctor” title. I think what was recommended by HPRAC in April 2006 around the use of the “doctor” title is something that the government actually should have adopted in this legislation. I regret that we are in a position now to deal with this issue, because the bill is opened, and we are not going to be dealing with it again. I would be very supportive of the use of the “doctor” title, not only with respect to social workers who have a doctorate, but also with respect to other health care professions when, as was noted by HPRAC, they have access to the same controlled acts. The amendments that I have would have done the same thing. Again, I regret the government is not doing this at this time because I’m not sure when this act will be opened again once it’s passed. I think we should have made the effort to do it now, especially given HPRAC’s directions.

**Mrs. Witmer:** Just further, when we consider that this act hasn’t been opened for 15 years, when we consider HPRAC’s recommendation, I have to say I am very disappointed that the government hasn’t moved forward in this regard. I hope they will consider some avenue in order to address the issue and support the amendment that I put forward and that has been supported by Ms. Martel.

**The Chair:** I will call the vote. Those in favour of the motion? Those opposed? The motion is lost.

NDP motion 113.

**Ms. Martel:** I move that section 19 of schedule Q to the bill be amended by adding the following subsection:

“(1.2) Subsection 30(1) of the act is amended by striking out ‘physical’ and substituting ‘bodily’.”

I would need to ask for unanimous consent for it to be—

**The Chair:** Exactly. It is out of order, so there is a request for unanimous consent to open subsection 30(1). Do I hear unanimous consent?

**Mr. Fonseca:** Agreed.

**The Chair:** Proceed.

**Ms. Martel:** Thank you. If you look on page 55 of the report by HPRAC, New Directions, there is specific mention of the harm clause. HPRAC made a very

specific recommendation around serious bodily harm. So the change that was put in here by striking out “physical” and substituting “bodily” was actually a change that came from a recommendation made by HPRAC under the section relating to the harm clause.

**Mr. Fonseca:** Just to clarify, the government does not support this motion to replace the word “physical” with the word “bodily” in subsection 30(1) of the RHPA because the amendment has already been proposed by the government in section 6 of schedule M of Bill 171.

**The Chair:** Any additional discussion? Those in favour of the motion? Opposed? The motion is lost.

NDP motion 114.

**Ms. Martel:** This would have put in place the use of the “doctor” title. It was what was proposed by HPRAC, but given the discussion that we’ve had on this, I will withdraw the amendment.

**The Chair:** This is out of order, so we’ll require unanimous consent.

**Mrs. Witmer:** She’s withdrawing it.

**The Chair:** Oh, she withdrew it. Trevor, you’re getting me into trouble.

Unfortunately, this is the last one: NDP motion 115.

**Ms. Martel:** As well, this amendment was put forward in relation to the use of the “doctor” title. We’ve had that discussion and the government’s not moving forward, so I’ll withdraw it.

**The Chair:** That completes the amendments. Now, we stood down—

*Interjection.*

**The Chair:** Okay, we’ve got to do these first.

Shall schedule Q, section 19, as amended, carry?

Shall schedule Q, sections 20 and 21, carry?

Shall schedule Q, as amended, carry?

We stood down the main body of the bill, so we will return to the beginning.

Shall sections 1, 2 and 3 carry? Carried.

Shall the title of the bill carry?

Shall Bill 171, as amended, carry?

Shall I report the bill, as amended, to the House?

Thank you very much. We’re adjourned.

*The committee adjourned at 1051.*

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